The (Extra) Ordinary Experiences and Practices of Rural Family Therapists

This is a thesis submitted in fulfilment of the requirements for the degree of Doctor of Philosophy

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Becoming, as an ethical feminist-researcher

In a voyage of becoming,
I move forward,
in the creation of a ship,
driven by sails of theoretical uncertainties,
constantly constructed, deconstructed and reconstructed,
as I go,
propelled upon the many and varied seas of feminisms.
Some seas are gentle as they climb onto coral coastlines,
a velveteen smoothness,
while others are harsh and unrelenting,
in their demands to claim back land into their depths,
as they feed upon these shores.
I immerse myself in my chosen feminist seas,
navigating by chosen feminist standpoints,
signposting my conduct while at sea.
My journey is to visit the shores of lands not yet known to me,
in a spirit of discovery of other peoples,
exploring spaces of being,
and belonging,
socially constructing new realities with others,
new spaces of social justice.
This is my own story of transformation and change,
of my own identity as researcher with and through others.
This voyage for me is a space of becoming,
a Deleuzian becoming,
becoming, as an ethical feminist researcher,
and so I begin again...

Abstract

This study aims to increase understanding and knowledge of Australian rural family therapists' experiences of practice. Nationally and internationally there is limited research about family therapists who work in rural regions. Professional and academic knowledge primarily focuses on the deficiencies of rurality for therapists, such as feeling professionally isolated and having limited access to education and supervision. Despite these challenges, rural family therapists continue in their practices, sustaining themselves and those families and communities with which they work.

Fourteen Australian rural family therapists collaborated in developing a research process to explore their experiences and practices of family therapy, with a particular focus on how they sustain themselves professionally. Influenced by social constructionist and feminist theories this qualitative study utilised a participatory action research strategy to co-construct stories with participants. Therapists from the New South Wales-Victorian border, Victorian and Tasmanian regions chose an ongoing focus group, a single small group interview or an individual interview.

Participants' individual stories were analysed as narratives to create the following overall themes which were linked to community connectedness:

- Understandings of rurality and rural family therapy practices.
- Experiences of transformation and change.
- Witnessing rural resistance and resiliency.
- Working with multiple relationships in rural communities.
- Traversing across issues of cultural, racial and gender differences.

Gritty narratives of participants' persistence, and everyday resistances to dominant understandings of rurality emerged. Alternative and dominant understandings of rurality come to sit alongside each other, offering rural practitioners differing perspectives to guide their practices. Participants unearthed an understanding of rurality as deeply relational, a community connectedness which sustains them professionally within small rural communities. Overall this study found that rural family therapists' experiences and practices were complex, diverse and specific to the localised contexts within which they lived and worked.

Student Declaration of Originality

I hereby certify that the work contained within this thesis is the result of original research and contains no material which has been accepted for the award of any other degree or diploma in any university or other institution. I affirm that to the best of my knowledge this thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

(Signed) 

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Acknowledgements

This PhD thesis is dedicated to my participants and other rural family therapists in recognition of the extraordinary therapeutic work they undertake with clients and their families, while living and working within small rural communities together.

I would like to thank my initial PhD supervisors, Dr Elmarie Kotzé and Dr Kathie Crocket, Te Whare Wananga O Waikato, University of Waikato, New Zealand, for their time and sharing of ideas at the start of this project. I commenced this study at Waikato University 2008 before transferring to Monash University, Australia, in 2012 to complete this project. A large thank you also goes to Monash library staff member, Myles Strous for his support in wrangling Endnote and Word program difficulties into line. Thanks also to Caitilin Punshon who provided copyediting and proofreading services and advice, according to the guidelines laid out in the university endorsed national Guidelines for Editing Research.

I am indebted to my current supervisors, Dr Anske Robinson and Dr Debra Manning, for their unswerving optimism, guidance and support in the completion of this study. Because of these wise women, I have retained a sense of myself within this study as a rural family therapist, mental health professional and emerging feminist researcher. To them I offer the following quote, in recognition of their contributions to this project:

> Of all that is good, sublimity is supreme. Succeeding is the coming together of all that is beautiful. Furtherance is the agreement of all that is just. Perseverance is the foundation of all actions (Lao Tzu, as cited in Wilhelm & Wilhelm, 1995, p. 60).

Conference presentations and publications related to this study

- Woodhouse, A. (2011).Traumatised communities...traumatised nurses? Australian Nursing Journal, Vol. 18 (10), 28.

- Woodhouse, A. (2010). Uniquely gifted or Disadvantaged? Co-research with psychiatric nurses and colleagues working as rural family therapists. Journal of Psychiatric and Mental Health Nursing, Vol 17, 935-93.

- "We're all in this together. Using Feminist Participatory Action Research with Rural Family Therapy Colleagues". Research panel presentation (New paper). 31st Australian Family therapy conference, Melbourne, 6th-8th October, 2010 Australia.

- "Tapestries of rural family therapy Practice: Interweaving strands of research theory alongside family therapy practices with rural colleagues". Conference presentation. Contemporary Ethnography across the Disciplines (CEAD) Hui, Waikato University, Hamilton, November 17th -19th, 2010, New Zealand. (Presentation of my project to this date).

- "Speaking the unspoken. Negotiating the intricacies of ethics, power and our relationships together within a feminist participatory action research project with professional rural colleagues". Conference presentation. 8th World Congress Action Learning, Action Research Association (ALARA): Appreciating our Pasts, Comprehending our Presents, Prefiguring our Futures, Melbourne, Australia 6th – 9th September, 2010.

- "We're all in this together. Using Feminist Participatory Action Research with Rural Family Therapy Colleagues". Conference presentation (Original paper). 5th World congress of Psychiatric Nurses, Vancouver, Canada, March 18-20, 2010.

- “Co-researching the (extra) ordinary experiences and practices of rural family therapists”. Conference presentation. 15th Qualitative Health Research (QHR) Conference, Vancouver, Canada, October 4-6, 2009. (Presentation of my project to this date).

- Woodhouse, A. (2009). Co-researching the (extra) ordinary experiences and practices of rural family therapists. International Journal of Qualitative Methods Vol. 8 (4). (Paper published from above conference).

- “Co-researching the (extra) ordinary experiences and practices of rural family therapists”. Conference presentation. 9th International Narrative Therapy and Community Work Conference, Adelaide, Australia, November 2008. (Presentation of my project to this date).

Chapter One. Introducing this research study

My interest in this topic comes from a lifelong personal curiosity in how people relate to each other, and from my therapeutic work as both a psychiatric nurse and a rural family therapist. I have worked professionally with people experiencing mental health issues as a psychiatric nurse for the past thirty six years. I have been involved with children, adolescents and families in urban and rural mental health services in New Zealand and Australia since the 1980s. This involvement has led to an interest in developing my family therapy skills to meet the needs of the families I was working with.

The relevance of family therapy has grown in importance to me both professionally and personally. Family therapy and all the different theoretical schools of thought contained within it have provided me with professional frameworks for practice that have prompted significant therapeutic impacts through my practice with clients. Family therapy has also given me a way of reflecting on and understanding my own life and family, which has been helpful personally. As a rural family therapist, I have found that the context of living and practising rurally is important to my practice.

The rural landscape itself and the relationships I have had with clients living within it have also been significant to me both professionally and personally. I was interested to know if these experiences were shared by other rural family therapists and to explore any implications these experiences may have upon our practice. I am currently involved in teaching rural family therapy and counselling practices as well as working as a rural family therapist in part time clinical practice. I have found that therapeutic approaches which consider the sociopolitical context (Anderson & Goolishian, 1988; Goldner, 1985b; Hoffman, 1990, 1992; Lax, 1992; Madigan, 1999; White & Epston, 1990) are most relevant to understanding and engaging with the issues families bring to therapy. The exploration of these issues and their links to the sociopolitical context offered within the therapeutic encounter creates opportunities for families to reconsider their relationship both to these concerns and their relevant contexts.

My initial ways of working therapeutically were predominantly based upon individual or couple based theories (Gottman, 1998; Peplau, 1997). However, I found that these approaches did not give the multiple realities, contradictions and complexities of the issues that families and I were grappling with sufficient standing to be addressed. For example, families I had seen in therapy were frequently from a background of domestic violence. They were socially isolated and often had few economic or educational resources. The young children of such families struggled to be accepted in the local schools and often they bought with them a legacy of destruction, with reports detailing their out of control behaviours and suggestions that schools should be wary of these children.

Using a framework with a consideration for the sociopolitical context when working with these families, I moved to eliciting stories from them that made sense of their behaviour and touched both my and others' hearts when they were shared in a professional context such as a school meeting. When these stories were retold in a professional context they resulted in the children and families being seen in a different way by schools and communities; one that was more accepting and nurturing of their abilities and potential. The children and their families were able to create a new identity that was more preferred by them and accepted by the school or community in place of the previous legacy of destructive stories.

Working rurally in Gippsland, Australia, has been the most challenging and fulfilling experience for me both personally and professionally. My experiences of being connected to rural families, communities and the land we live on together have shaped my identity as a rural person, nurse and family therapist. This new identity for me as a rural family therapist was co-constructed by the sharing of stories and ideas of practice together with professional colleagues and while teaching family therapy students. In our discussions, new ideas and potential ways of being as rural family therapists were co-created between us. Social constructionism suggests that language constructs our realties as we talk together (Freedman & Combs, 1996). The new identity created for me from discussions with my colleagues and students demonstrates a social constructionist view of reality and forms the basis of my theoretical understanding and the methodology for this study. My intention for this research is to contribute to an increased understanding of rural family therapy

identities within the wider therapy community while sustaining myself and other individual rural therapists.

1.1 Why research rural family therapy?

Discussions with rural family therapy students and colleagues in Victoria and Tasmania, prior to undertaking this study raised questions for me, such as “How do we support and sustain ourselves not only as individual practitioners, but also as a unique professional group”? Family therapy students and colleagues gave me feedback that having conversations together and considering possible answers to this question was useful to them for their practice, as we spoke of ideas not previously discussed with others.

In talking together, new understandings and ideas of rural family therapy practice were explored, allowing us to consider their relevance to our practice. These ideas were valued as they came from therapy colleagues experiencing similar issues in practice. In addition, these conversations contributed to the overall understanding of rural family therapy for a group of students I was previously teaching. Our meeting together for family therapy training was the only rural professional forum available for many to have these discussions. This forum allowed for questions which we had been carrying in silence to be discussed. These ideas and conversations were influential in the later development of my research questions for this study.

During these conversations with colleagues and students we talked of our rural practice, and shared experiences which did not fit with what was cited in the literature. For example, our experiences of the closeness of our relationship with rural clients and families gave us a sense of hope and belonging, sustaining us in our practice. This differed from views expressed in the literature, where therapists were cited as being professionally isolated (Hart, 1986; Saunders, 1989), or having the potential for facing professional dilemmas by having multiple relationships as therapists and community members with rural clients (Erickson, 2001; Weigel & Baker, 2002). I came to understand our experiences as (Extra) ordinary during this research. Not only did our practices contrast with the literature, we called upon them to understand and connect with each other, our clients and our communities as we

faced the complexities of rural practice together. My colleagues' responses to these initial questions were catalysts to this research, as our conversations together allowed for other ways of understanding the ways we relate to rural families and communities to be considered. The present research aims to ask how these conversations might be continued in ways that contribute to professional knowledges of rural family therapy while simultaneously sustaining therapists in practice.

These initial professional pre study discussions motivated me to review family therapy literature for rural family therapists' practices and experiences. The literature was very limited and highlighted the need for more research (Morris, 2006). This literature deficit combined with my specific theoretical orientation towards social constructionist thinking, specifically narrative therapy theory and feminist theory, compelled me to ask, "Why is there a lack of research into the practices and experiences of rural family therapists"? In addition, my own learning from narrative therapy has guided me to consider not just what was known in the limited literature I had reviewed but also what was not known (Anderson & Goolishan, 1992) and the deficit focus of the available literature on rural family therapy.

My understandings of feminist theory required me to consider how my research could contribute to the communities I am part of both professional and personally. Poststructuralist feminism (Weedon, 1987) invited me to consider my ethical stance towards the usefulness of my research to participants and other women, such as fellow therapists and the women they work with. Feminist researchers Reinharz (1992) and Olesen (2005) stress the importance of attending to the relationships between researchers and their participants, as the research process invites not only participants but researchers themselves into new positions. These suggestions have been influential in the methodologies chosen for this study and are discussed further in Chapter Three.

Given the limited rural family therapy literature, I sought out professional family therapy colleagues, teachers, editors and the former professional organisation of my state, the Victorian Association of Family Therapy Incorporated (VAFT). I asked them what they knew of rural family therapists and their practice. VAFT subsequently became part of a new national body for family therapists, the Australian Association

for Family Therapy (AAFT). An important moment in these consultations was when I asked the co-editor of the *Australian and New Zealand Journal of Family Therapy* (*ANZJFT*), Maureen Crago, about her views on the rurality of family therapy practice. Both Hugh and Maureen Crago (1989, 1997, 2002) have written on rural family therapy. They also have a wide knowledge of family therapy and therapists in Australia and New Zealand. Maureen Crago (personal communication, 27 June, 2007) identified that future research needed to focus on the meaning of living and working rurally for rural family therapists and how we sustain ourselves in our professional practices enriched by this rurality. I have reflected on her thoughts in the development of this study and wish to acknowledge her contribution here as it strengthened my move towards considering how my study might contribute towards sustaining therapists in practice rather than just focusing on deficits identified in the current rural literature.

In the face of limited and primarily deficiency-orientated literature on rural family therapy, my aim for this study was to work with Australian rural family therapists to move my beginning conversations about rural family therapy with students and practice colleagues into the research arena. Here our experiences and stories of rural family therapy could be reflected on and analysed together, as a form of participant action research which is described in Chapters Three and Four. My hope was that new ways of understanding what it means to work rurally would be more sustaining of practice, and contribute to professional knowledge of rural family therapy. By sustaining ourselves professionally my hope is that we can remain available to families in the face of rural adversities.

An example of such adversities is the ongoing drought which is having a significant impact on Australian rural families and communities (Alston & Kent, 2008; Fuller & Broadbent, 2006; Morrissey & Reser, 2007). Climate changes in Australia indicate that temperatures are consistently becoming warmer and that this has accelerated recently (Australian Bureau of Meteorology, 2007). In light of this change it would be expected that the drought conditions currently affecting Australian rural regions will continue to be an ongoing issue for rural families. This matter is discussed further in my literature review Chapter Two. My research questions and objectives for this study are presented next.

1.2 Research questions

How does rurality shape Australian family therapists' sense of themselves and their practice?

How does practicing in rural Australia shape family therapists' sense of themselves and their practice?

How do Australian family therapists sustain their professional practices, and themselves as people while working within rural contexts?

1.3 Thesis outline

Chapter One. This introduction introduces this research study. It explains my personal and professional involvement in the research topic and my interest in the philosophical theories informing this study. This introduction also includes the thesis outline.

Chapter Two. Exploring rural family therapy: The literature review provides a comprehensive review of the literature from the broad international field of rural therapy and counselling in general to specific literature related to the Australian rural family therapy context. This broad to specific focus is intended to provide an overview and introduction to the general field of rural counselling and therapy, and the related issues involved. The review then continues with the specialist topic of rural family therapy within an Australian context. International and Australian research and academic articles that contribute significantly to the research topic are included in this review.

Chapter Three. My dinner party discussions with theorists discusses the theoretical approaches from social constructionism, feminisms, participant action research approaches, alongside influences from French philosophers Foucault

(1980), Derrida (Derrida,1982; Hepburn, 1999) and Deleuze (Deleuze, 1988;1995; Davies & Gannon, 2009; St. Pierre, 2001) utilised in this study. I situate myself within this study as an insider feminist researcher, using feminist strategies of reflexivity (Reid & Frisby, 2008) and transparency (Etherington, 2007; Reinharz, 1992) to inform readers of my use of selected theoretical concepts, and the impact of these on the development of research practices with my participants. My purposeful use of these concepts was to allow for the multiple realties and complexities of rural family therapy experiences and practice to be explored with participants while paying attention to issues of power and gender.

Chapter Four. Constructing research processes with participants presents the practical research processes used for this study and my account of creating my analysis. I introduce readers to my results chapters which follow, and discuss relevant post-research issues and realities.

Chapters Five to Ten present the results, analysis and themes of the experiences and stories from the two research groups and the individual interviews on the research topic.

Chapter Five. What is rural, what is rural practice? discusses dominant urban-based understandings of rurality as a deficiency and considers issues of: a loss of rural connection within communities related to governmental restructuring, for example the closure of local banks and schools; travel, isolation and restricted access to professional development for rural family therapists; mental health access and issues of social justice for rural families; gender issues in rural environments; stress on rural families arising from traditional rural attitudes and circumstances, such as the suicide of male farmers, cattle grazing; the Gippsland Black Saturday bushfires, and differences between rural and urban contexts.

Chapter Six. Rurality as resistance, resilience and connectedness discusses new understandings of rurality as a resistance to dominant urban based understandings of rurality as lesser than rural. Drawing upon my own understandings of Foucault's (1980) work on power and resiustance, I analyse my own and my participant's stories, to offer hope to other practitioners seeking non-deficit

understandings of rural practices. Rurality is understood in an emerging counter-narrative as relational. That is, rurality is perceived as a relationship between family therapists, our clients and local rural communities which sustains us in our professional practices. This new counter-narrative begins to emerge in this chapter and is subsequently built upon in following chapters.

Chapter Seven. **Dorothy's story: A journey of transformation and change** presents a story of experiencing transformation and change for one rural family therapist, Dorothy. Theories from family therapy transformed Dorothy's mental health work with families. This chapter offers an intimate account of her experiences and practices while doing so. Dorothy's perspectives on rural family therapy training, as both a student and a teacher are also presented. They identify the need for a critical mass of family therapists to achieve change. This chapter calls upon the theoretical work of Deleuze (Deleuze, 1988; 1995; Deleuze & Guattari, 1987) to present an understanding of Dorothy's story of transformation and change and affirms emerging new understandings of rurality as relational.

Chapter Eight. Rural family therapists working with differences of race, culture, class, rurality and gender explores intersectionality issues of racial, cultural, rurality and gender differences through the presentation of rural family therapists' stories which grapple with these issues. Rurality in this chapter is understood as diverse and contextual. Calling upon a Foucauldian practice of problematisation (Neal, 2009), I explore the struggles of my participants to be socially just in their practices with Indigenous families within wider sociopolitical and historical contexts. These contexts include a history of the colonisation of Indigenous peoples in Australia and privileging of westernised white knowledges during this time (M.Green & Sonn, 2005; L. Smith, 1999; Young & Zubrzycki, 2011).

Chapter Nine. Multiple relationships in rural communities discusses the complexities and understandings of multiple relationships for family therapists within rural contexts. This includes stories from family therapists that demonstrate these complexities, such as ethical issues of confidentiality. In addition, the importance of a community connectedness for practitioners is identified which offers a new

understanding of rurality as relational and complex for professionals working with these complexities.

Chapter Ten. Rural family therapy training presents a summary of participants' suggestions, from their collective wisdom over the past one to two decades, for the teaching of family therapy within rural contexts This includes practical suggestions, such as how to teach effectively within a rural context and notions of therapist self-care, as well as considering local contexts and acknowledging the thirst for knowledge by many rural family therapists due to their isolation and restricted access to professional development.

Chapter Eleven. Discussion considers new understandings of rurality from my analysis of my participants' practice and teaching experiences that have come out of this study, for their significance to other rural practitioners. Important challenges and considerations within this study are also considered, alongside my own learnings as a beginning feminist researcher. Keeping in mind the social constructionist view that this study is just one of many possible stories of rural family therapy practice, and that no one story or experience is the only truth, my intention is that this study will contribute to knowledge within the wider therapy community and towards the growing body of literature aimed at providing an understanding of rural issues in Australia.

Chapter Twelve. Conclusion. Consistent with poststructural feminist theory (Davies, Gannon, Hopkins, McCann & Wihlborg, 2006), this chapter offers an incomplete summary of the main findings of this study, and the potential impact of these for other rural practitioners and myself as a feminist researcher.

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1.4 Chapter summary

This chapter has introduced the purpose of this study, which is to increase knowledge and understanding of rural family therapists' experiences of practice in Australia. Thesis chapters have also been outlined. Theoretical influences of

feminism, social constructionism, and participatory action research (PAR) research approaches, alongside influences from French philosophers have been presented as concepts which guided the development of this project. The rationale for undertaking this project and linkages to my own professional practices as a rural family therapist has also been discussed. My aim in undertaking this research, together with my research objectives and research questions have been presented. I move next, in Chapter Two, to exploring literature related to rurality, rural health, rural counselling and family therapy to provide a framework for this project's direction, data generation and analysis which follow in subsequent chapters.

Chapter Two. Exploring rural wellness and rural wellbeing

2.1 Introduction

There is little in the literature about those family therapists who work in rural regions (Morris, 2006) other than the challenges they face, which include isolation, geographical distance and lack of resources, such as supervision and training (Crago & Crago, 2002; Hart, 1986; Weigel & Baker, 2002). Despite these challenges rural family therapists continue in their practices, sustaining themselves and the families and communities they work with. This chapter reviews literature relevant to this study including understandings of rurality from both traditional and alternative perspectives. My purpose in presenting these differing perspectives is to reflect the complex understandings of rurality found within the literature

This review also situates my research topic, the experiences and practices of rural family therapists, within the broader literature on rurality and rural practitioners, before I specifically focus on rural family therapy literature. It is important to look at the nature of rurality and rural practice, so that I can contextualise where these practitioners are working. I therefore present my literature review in two parts.

Part one of this review considers rurality from both international and Australian perspectives. This includes traditional views of understanding rurality, such as rural locations and health status, classification systems, demographic data, health status of rural populations, along with recent concerns highlighted within the literature about rural wellness and wellbeing. I also explore alternative understandings of rurality, such as valuing gender and cultural differences, conceptualising rurality as small communities and geographically as these were the most significant aspects of rurality for a number of my participants.

Part two of this literature review then moves from the broad context of understanding rurality, to considering more specific literature related to the research topic. Much like a funnel, I employ a strategy of a decreasing field of focus which

explores rurality and practitioner issues identified within the literature in relation to rural wellness and wellbeing.

This review identifies a gap within the literature of the experiences and practices of rural family therapists, and contributes to the development and direction of this research study to address this deficit. I conclude this literature review by summarising perspectives and understandings of rurality and the practice of rural professionals.

2.2. Part one: Rural locations and health status

Attempts to understand and define the term rurality are complicated by ongoing discussions of what this means, both nationally and internationally (Coburn et al., 2007; Couper, 2003; R. Green & Gregory, 2004; Hugo, 2002; Kelly & Smith, 2007; Maidment & Bay, 2012; Munn & Munn, 2003; Pitblado, 2005; Pizzoli & Gong, 2007; Pugh, 2003; Pugh & Cheers, 2010; K. Smith, Humphreys, & Wilson, 2008). Traditionally, rurality has been understood internationally by the use of classification systems to define it from non-rural (Wakerman & Humphreys, 2008). The current Organisation for Economic Co-operation and Development (OECD) (2011) global classification system is based upon the population density within a given country.

2.2.1 Demography

Australia is a vast land with a diversity of people, culture and landscapes. It extends from the tropical rainforests of the north to the parched desert interiors of the outback and onwards to the farming lands of the south. Australia offers different climatic conditions, cultural communities and locations for those who live within her states and territories. As a landmass, Australia is the world's largest island and similar in size to the United States of America (Kelly & Smith, 2007). The population is approximately 23 million (Australian Bureau of Statistics [ABS], 2012b). While Australia has a large landmass the population is small and highly urbanised in comparison to other westernised countries (Organisation for Economic Co-operation and Development [OECD], 2011). Population is predominantly located in cities along coastal regions with 2.8% of the landmass occupied by 90% of the population (Pugh & Cheers, 2010). The states of New South Wales, Queensland and Victoria have

had significant growth in their population in coastal cities and suburbs, while more inland rural and mining regions have a declining population, related in part to climate change (Maidment & Bay, 2012).

Events such as extreme weather conditions and drought are impacting significantly on rural and remote populations (Alston, 2012a). Changes in these rural populations include the movement of young people to urban regions for employment and education resulting in an ageing rural workforce. The movement of young women to cities is resulting in gender imbalances in rural regions (Maidment & Bay, 2012) .There is also a trend of urban populations moving to rural regions known as 'sea-changers' or 'tree changers', who are retiring or seeking a rural lifestyle or cheaper housing, creating socioeconomic changes in these regions (Wendt, 2012).

Diversity exists not only within the landscapes of Australia but also within the peoples who make up the population. Indigenous peoples make up 2% of the Australian population and are more likely to be located in rural and remote regions of Australia (Pugh & Cheers, 2010). Immigration has played an important part in Australia's history, from the early migration of transported criminals from Europe, planned migration programs following the Second World War, to current policies which facilitate immigration to address economic growth (Australian Government Department of Immigration and Citizenship, 2012a). This history of immigration has contributed to the current Australian population status, whereby one quarter of Australia's population was born overseas (Australian Government Department of Immigration and Citizenship, 2012a).

The most recent Australian statistics indicate a change in migration patterns. There has been a drop in migration from the United Kingdom and South Africa with current migrants predominantly coming from the People's Republic of China (13.8%), New Zealand (12.1%) and India (10.3%) (Australian Government Department of Immigration and Citizenship, 2012b). New migrants who live in Australia permanently mostly reside in New South Wales (31.1%), Victoria (25.2%) and Queensland (18.4%). The majority of these migrants choose to live in major cities (Australian Government Department of Immigration and Citizenship, 2012b).

2.2.2 Classification systems used to define rurality

Given the variations of demographics across westernised countries, different classifications systems for rurality are used (Pugh & Cheers, 2010). For example, the United Kingdom uses a system based upon demographics (Siaw-Teng & Kilpatrick, 2008), while Australia uses remote area designations to define rural (Health Policy Analysis, 2011). The United States of America (USA) uses a wide variety of classification systems predominantly based on rural not being urban (Wakerman & Humphreys, 2008). The two most commonly used systems by the USA Census Bureau and Office of Management and Budget define rurality differently, impacting significantly on health policy and the funding of services (Coburn et al., 2007). Overall there is no common means of defining rurality across countries although research has considered comparisons of rural and urban health status between countries with similar demographics, such as Canada and Australia (Pong, DesMeule, & Lagacé, 2009). Findings from this research indicated that while there were some similarities in health status investigated across these two countries, unique aspects remained that require further investigation.

Classifications of rurality are complicated by the terminology used internationally. For example, the term 'region' has different meanings within and across countries. Thus, a region in one country can have a totally different land mass and population compared to a region in another country (Organisation for Economic Co-operation and Development [OECD], 2011). This lack of consistency in describing rurality is also reflected in an Australian context. Terminology used to describe rurality includes rural, regional and remote (Hugo, 2002), along with isolated and non-metropolitan (Kelly & Smith, 2007). While these terms are useful in understanding some of the differences between these regions, it is not possible to capture all of the diversity of Australia's rural regions and peoples within a simplistic rural/urban demarcation (Kelly & Smith, 2007).

2.2.3 Australian rural classification systems

Australia's rural classification systems inform the allocation of governmental funding of services, including health (Kelly & Smith, 2007; McGrail, 2009; McGrail & Humphreys, 2009a, 2009b). These classification systems understand rural in relation

to being remote or removed from urban centres, in terms of service accessibility, or as communities with small populations (McGrail, 2009; McGrail & Humphreys, 2009a; McGrail et al., 2005; Siaw-Teng & Kilpatrick, 2008).

Three main systems have been used to classify rurality in Australia. These are:

1. The Rural, Remote and Metropolitan Areas (RRMA) classification
2. The remoteness classification based on the *Accessibility/Remoteness Index of Australia* (ARIA)
3. Remoteness Areas (RAs) defined under the Australian Standard Geographic Classification (ASGC) (Health Policy Analysis, 2011).

1. The Rural, Remote and Metropolitan Areas classification (RRMA)

The RRMA classification was developed by the Department of Primary Industries and Energy (DPIE) and the Department of Human Services and Health, (DHSH) in 2004. It was used by the Commonwealth Government from the mid-1990s to 2008. Rural was understood as the size of a population and its relation to three nominated regions: rural, remote or metropolitan/urban (Health Policy Analysis, 2011).

2. The Accessibility/Remoteness Index of Australia (ARIA)

The ARIA system was created for the Australian Government by the Social Applications of Geographical Information Systems (GISCA) and understands rural geographically, in term of remoteness. This is considered as:

> The road distance that people have to travel in order to gain access to services. The further an individual has to travel to access services, the more 'remote' a locality is considered (Health Policy Analysis, 2011, pp. 193-194).
>
> This allows for a 'remoteness score' of five levels to be developed for communities according to their distance from the nearest service centre (Health Policy Analysis, 2011; McGrail et al., 2005).

3. The Australian Standard Geographic Classification (ASGC)

The ASGC, also known as ARIA+, is based upon modifications to the original ARIA. It has become the standard system currently used by government departments (Health Policy Analysis, 2011; McGrail et al., 2005). While ARIA+ retains the original five levels of remoteness, new boundaries and extended distances for communities

have been added, creating five rather than the previous four service centres (Health Policy Analysis, 2011; McGrail, et al., 2005). A scoring system measures distances in kilometres from the measured locations to their nearest service centres. The groupings of rural regions are shown in table 1 below:

Table 1: ARIA+/ASGC classification system

Grouping	Code	ARIA+ range
Major cities	RA1	0–0.2 km
Inner regional	RA2	> 0.2 - 2.4 km
Outer regional	RA3	>2.4–5.92km
Remote	RA4	>5.92–10.53 km
Very remote	RA5	>10.53 km

Structure of ASGC Remoteness Areas (RA) classification (Australian Insitute of Health and Welfare cited in Health Policy Analysis, 2011)

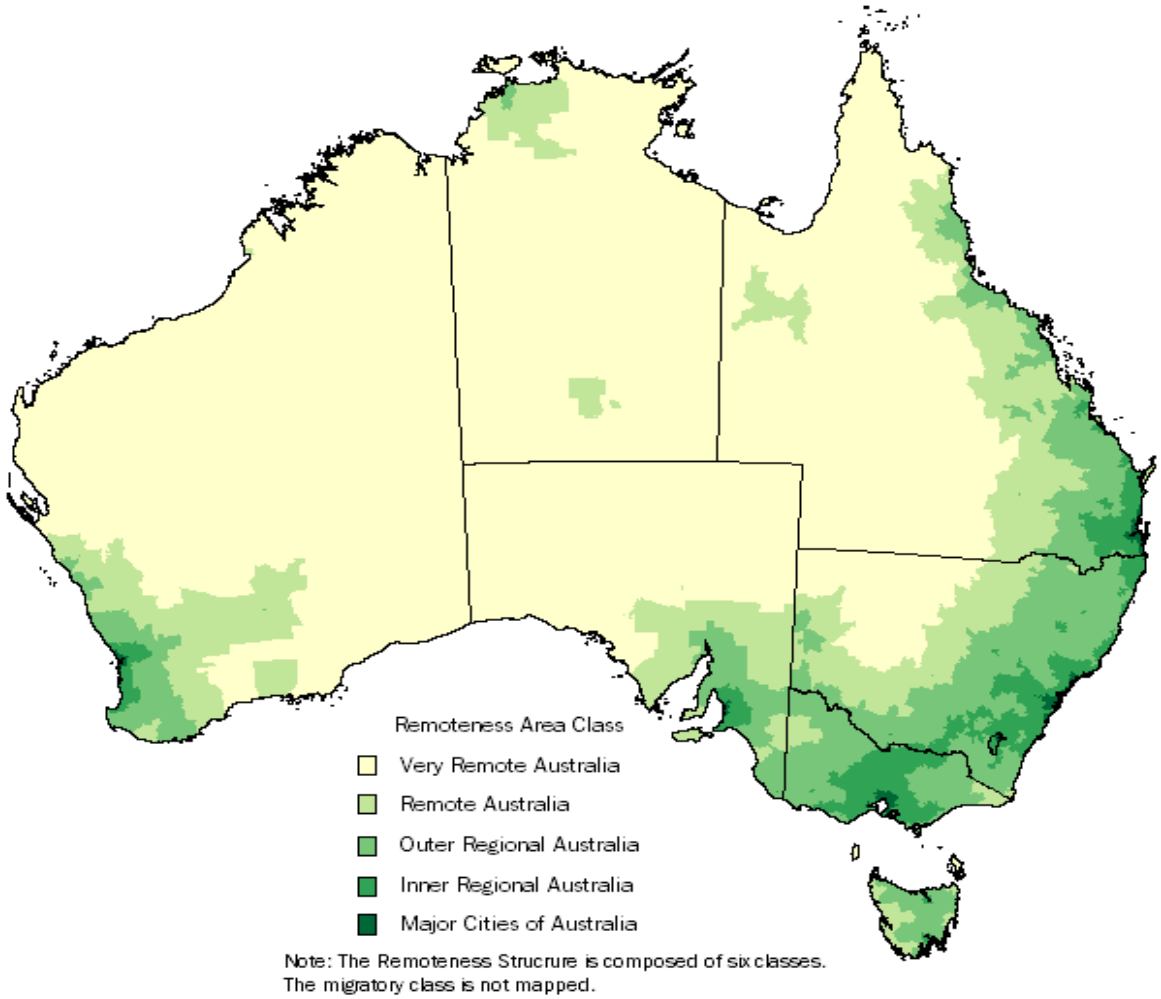
This classification system is the one currently used to designate rural in Australia (Health Policy Analysis, 2011). A review of the ARIA+ system by the National Centre for Social Applications of Geographical Information Systems (GISCA) conducted in 2011 considered concerns from rural regions over their rankings in the ARIA+/ASGC classifications. These concerns included that:

> The ABS [Australian Bureau of statistics] used a minimum population to draw the boundary between remote and very remote categories [creating] ... problems of similar places finding themselves either side of a boundary. We consider that this needs to be recognised and we have drawn an ‘area of uncertainty’ (emphasis as in original) around the boundaries (National Centre

for Social Applications of Geographical Information Systems [GISCA], 2011, p. 3).

Recommendations from this review included a reassessment of these rural 'areas of uncertainty' by a designated panel with representatives from health, education and the Commonwealth Government (GISCA, 2011). Figure 1 is a map representing the ASGC Remoteness Areas (RA) classifications from the Australian Bureau of Statistics (ABS), 2011b.

Figure 1: Remote Area Classification.



2.2.4 A new Australian Index of rural Access

While rurality is traditionally defined by classification systems and demography, as outlined above, there is criticism within the literature that these definitions and classifications do not always capture the diversity of rural contexts (Kelly et al., 2010;

Kulig et al., 2008; McGrail & Humphreys, 2009a, 2009b; McGrail, Humphreys, Joyce, & Kalb, 2011; Pugh, 2003). For example, within current classification systems relevant social, cultural, and economic issues are often excluded (Kelly et al., 2010), as well as issues of access to housing, local services and employment (Pugh, 2003).

Rural indexes have often understood rurality as a fixed concept rather than a fluid one. Kulig et al. (2008) suggests that systems which measure rurality use both qualitative as well as quantitative data to capture not only population size and geographical distances, but also social aspects of individual's lives and relationships between community members. An example of research which highlights the value of considering social aspects suggested by Kulig et al. (2008), is a recent Australian study by McGrail et al. (2011). These authors explored whether there was any relationship between medical workforce shortages and contextual factors of rural locations such as environment, geography, social and community factors. Their findings indicated a need for more research into why medical staff choose to live and work where they do, including a consideration of social, economic, and geographical influences. A more comprehensive understanding of these influences would allow for the development of more targeted approaches to the recruitment and retention of health staff (McGrail et al., 2011).

Within an Australian context, geographical classifications also play an important part in the allocation of health resources (McGrail, 2009; McGrail & Humphreys, 2009a, 2009b). However geography alone cannot measure all aspects of service provision (McGrail & Humphreys, 2009a). Issues of subjectivity, in relation to decisions made during measurement calculations, significantly impact upon the fairness and effectiveness of distributing health resources (McGrail & Humphreys, 2009a). While recognising that no one rural classification system will meet all needs, McGrail and Humphreys (2009a) developed a finer geographical scale, called an Index of Rural Access, which is able to identify issues of disadvantage in relation to health accessibility and services in rural regions (McGrail & Humphreys, 2009b). This new Index of Rural Access considers several factors relevant in accessing health services, such as the availability of services (availability), distance and time to services (proximity), the level of need of people seeking services (health care need),

and access for individuals to services when required (mobility) (McGrail & Humphreys, 2009b).

McGrail and Humphrey's (2009a, p. 5) new index system is designed to take into account barriers in relation to these factors so "people experiencing similar characteristics and problems of location and environment fall within similar categories". This has not always been the case within Australian rural classification systems, where differing populations are seen as the same. Both rural communities and practitioners delivering health services, are impacted upon when health needs are classified as homogenous by current rural indexes (McGrail & Humphreys, 2009a). McGrail and Humphrey (2009a, p. 5) give an example of this from the Australian Standard Geographic Classification Remoteness Areas system (ASGC-RA), noting that under this classification:

> highly dissimilar localities [are seen] as being 'equal' (such as Bendigo – large regional centre with a population of almost 100,000 and Rushworth – a small rural town with a population of only 1,000).

This new index from McGrail and Humphrey (2009a) offers an alternate measurement system which is more finely tuned to geographical differences within rural contexts of Victoria, and potentially to other regions of Australia. This index could provide valuable information to government departments, thereby offering a means to develop a more equitable and effective delivery of scarce health resources.

2.2.5 All rural is not the same

Alongside traditional definitions of rural, such as the use of the ARIA+ classification system within Australia (Health Policy Analysis, 2011) and McGrail and Humphrey's new index (2009a) discussed above, alternative understandings of rurality also exist. Discussions within international and national literature suggest that rural contexts are not the same (Brownlee et al., 2009; Australian Government, 2011; Maidment, 2012; Woods, 2006). For example, within an Australian context the terms rural and remote are often used interchangeably. However, remote and very remote communities (as defined by the ARIA+ classification system) have their own specific issues related to their geographical isolation, including having smaller communities, limited public

transport, and fewer (if any) health services (Commonwealth of Australia: Standing Council on Health, 2012). Rigid representations of what is urban, rural and remote allow for only limited understandings of these contexts that are usually based upon population statistics. Bodor, Green, Lonne, and Zapf (2004, p. 56) suggest:

> the true meaning of rural and remote is understood only through the stories that are shared – in contrast to an imperialistic belief that there may be a definitive definition or ultimate truth of what is rural or remote.

Pugh and Cheers (2010) echo calls to consider rurality more holistically. They suggest that while there is some acceptance within the literature that rural and remote contexts have some characteristics in common, we require a "sophisticated appreciation of local context … [to move us] beyond a discussion of the demographics of rural life into a broader appreciation of the social dynamics of rural life" (p. xi). In a similar vein, Wendt (2009) offers that rural contexts cannot be generalised. We should abandon the search for one definition of rural culture and instead focus on "how places are made, multiple meanings and identities in a place" (Wendt, 2009, p. 3). By considering rurality differently we move away from an understanding of rural communities as being only the sum of their demographic data and towards understanding the social aspects of rurality (Bourke et al., 2012; Pugh, 2003; Pugh & Cheers, 2010). This opens up opportunities to consider perspectives from those people who have been marginalised by current systems defining what is (and is not) rural (Pugh, 2003). Examples of this exclusion within an Australian context include the experiences and histories of rural women and Indigenous peoples (Maidment, 2012). Understanding social aspects of rurality is relevant to rural family therapists, as it establishes a context within which they both live and work with clients. Focus group participants of this study identified issues of gender, racial and cultural differences as important aspects of their practice with families within a rural context.

While dated, Dempsey's (1990) seventeen year long study of a small Australian rural community continues to have relevance to current understandings of Australian rural life, including issues of gender. While rural communities are often portrayed as somewhat idealistic locations to live because of the perceived closeness of their communities which some "liken to a family" (p. 314), Dempsey's study uncovered

that this experience may not be true for all inhabitants. He provides intimate details of residents' lives which demonstrate that inequities of class, gender and age were embedded within the study's rural community. Not everyone in his 'smalltown' community felt accepted or had a sense of belonging; marginalisation and the exclusion of some peoples perspectives occurred here as it does in other communities, both rural and urban. These findings suggest that residing within a small rural community may not live up to the ideal offered.

Issues of gender recognised in Dempsey's (1990) study have been identified in more recent literature. For example, Maidment, (2012, pp. 11-12) suggests Australia is a 'blokeland' where rural life is portrayed within the media and popular literature predominantly through images of "tough, unyielding characters – usually men … the masculine battler". These stereotypical characterisations of rurality exclude experiences of women, and until more recent times the histories and experiences of Indigenous peoples during the initial colonisation of Australia. Maidment (2012) proposes that the predominant portrayal of rurality within the Australian popular media has been the experiences of white westernised males. This predominance of white peoples' perspectives is also reflected internationally; Indigenous peoples' perspectives have been excluded within primarily westernised reviews of health (Pugh & Cheers, 2010). The predominance of white westernised perspectives of health, and exclusion of non-white westernised perspectives, is an important aspect of health care for practitioners to understand in order to work in more inclusive ways with previously excluded populations, including women and Indigenous communities. In considering understandings of rurality from an Australian Indigenous peoples' view, definitions of wellness and wellbeing differ from those used in current health systems, such as quality of life measures and health status previously cited. From an Indigenous peoples' perspective, wellness is understood more holistically, and includes an important attachment to their land. In this view, health is:

> not just the physical well-being of an individual but … the social, emotional and cultural well-being of the whole community in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their community (National Aboriginal Community Controlled Health Organisation, as cited in Bourke et al., 2012, p.497).

This definition is a useful one in considering alternative understandings of rurality which are more inclusive of Indigenous peoples. Also useful is the understanding of an attachment to land and the relevance of this to Indigenous peoples' lives and their social, emotional health and wellbeing (Rigby et al., 2011).

In considering alternative understandings of rurality which are more inclusive of gender, the experiences of rural men and women enduring climate change, including drought, are relevant. Research by Alston (2011, p. 65) found that men are more likely to be focusing upon:

> …generally coping with the realities of a barren and eroding landscape … feeding livestock, carting water, and destroying frail animals … [while women] are more likely to be assisting with farm tasks and working off the farm for the much needed income.

The results of this in terms of wellbeing are that, "men are more likely to be locked into the farm, becoming socially isolated and depressed … [while] women are more likely to be interacting in the community, monitoring the health of their own family and ignoring their own health and welfare (Alston, 2011, p. 65). Alston's (2011, 2012a, 2012b; Alston, Kent, & Kent, 2004; Alston & Kent, 2006, 2008) research on climate change and its social impact upon rural communities over the years 1994 to 2007, reveals a "significant crisis" (Alston, 2011, p. 67) in rural communities. Males and females are reacting differently to climate change (Alston, 2011, 2012b; Alston & Kent, 2008). Their responses are gendered and therefore a gender sensitive response is required to address this (Alston, 2011).

High rates of suicide in rural males are related to how males perceive themselves and their masculinity, including having a stoic attitude, "[meaning] an ability to work through hard times ... [Causing them to be] unable to seek assistance and blame themselves" (Alston, 2012b, p. 521). Alston's research has relevance for health practitioners who are working with rural communities around mental health concerns, including suicide prevention. By understanding differences in gender reactions to current drought conditions, rural practitioners are provided with opportunities to understand and engage differently with male and female clients within rural

communities. Interestingly Bryant and Pini (2009, p. 56) alert those interested in understanding rurality to consider not only issues of gender but also of class as these issues are “mutually constitutive and intersect in rural settings”.

2.2.6 Understanding rural as ‘small communities’

International literature suggests that while rural and urban may previously have been represented as two distinct and opposing concepts, an intermingling of the two has occurred. Cloke (2006, p.18) proposes there has been a:

> blurring of conventional boundaries between city and country… also that such blurring works in both directions, indicating an urbanization of the rural and (albeit to a lesser extent) a ruralization of the urban. Urbanizing the rural has occurred via an interwoven tapestry of cultural, social and economic trends.

Within an Australian context, diversity exists within both rural and urban populations as previously discussed. However the place of agriculture and farming remains significant to the economy (Australian Government: Department of Agriculture Fisheries and Forestry (ABARES), 2012) and therefore continues to be a significant part of many rural Australians’ lifestyles.

There has also been discussion as to whether rural contexts are themselves unique (Pugh & Cheers, 2010; Pugh, 2007). For example, Helbok (2010, p. 505) calling upon the work of Schank (2010) suggests that “many small communities, sometimes located within a larger urban community, often share characteristics similar to a rural community [including] … the deaf community ... gay and lesbian clients … specific ethnic or religious groups”. This suggestion of small communities being encapsulated within a larger population, and having similar issues to rural contexts, is supported in the literature (Gallardo, 2010; Halderman, 2010). Pugh and Cheers (2010, p. x) suggest that rather than understanding rural and urban as opposite to each other, we could instead consider, “the diversity of rural areas, together with the crucial importance of how variably people may subjectively experience the place and their position within the community”.

Pugh calls upon the work of Martinez-Brawley (2000) and her concept of ‘small communities’ to define rurality. Rural is understood as small communities with all the

associated complexities previously discussed for practitioners and clients, such as high visibility and issues of confidentiality. The definition of rural as small communities transcends divisive debates in defining rural and urban as opposites, which is not always helpful. It also captures the complexities of local rural contexts and social dynamics within these places, which has been called for in previously cited literature (Bodor et al., 2004; Brownlee et al., 2010; Pugh & Cheers, 2010; Wendt, 2009). A concept of rural as small communities has relevance for rural practitioners. Rurality can be understood in more complex terms than as the opposite of urban. In this definition, it is inclusive of the contextual and subjective experiences of clients and practitioners within their rural communities.

2.2.7 Geography and health

Recent literature has also considered the value of geography to rural health care practices (Boyd et al., 2008; Castleden, Crooks, Schuurman, & Hanlon, 2010). Boyd et al. (2008) propose that much of the previous research in mental health has ignored “contextual or collective characteristics of rural communities” (p. 4). To address this, they suggest a combined focus on understanding the place of rurality *and* of health in relation to this. They refer to research by Parr and colleagues on social geography as an example of this (Parr & Philo, 2003; Parr, Philo, & Burns, 2001, 2004). Parr et al. (2001, 2004) considered the “collective social functioning of rural communities” (as cited in Boyd et al., 2008, p. 2), thus providing useful understandings for health practitioners of participants’ help seeking attitudes. Boyd et al. (2008) also utilised a concept of the "rural paradox of proximity and distance” (p. 4) from Parr, et al. (2001, 2004) to understand mental health issues of stigma and isolation within their research. Boyd et al. (2008, p. 4) explain this concept as:

> In rural environments, community members may be separated by many kilometres yet they can be considered socially proximate in that they can have intimate knowledge of each other’s lives. In urban environments, the opposite sociospatial relationship usually exits whereby community members tend to be physically proximate yet socially distant.

This concept of rural paradox provides a further alternative understanding of rural and urban contexts in terms of social functioning and geographical distances. This

concept has value for those practitioners seeking extended understandings and engagement with communities around issues of mental health and wellbeing.

Research by Castleden et al. (2010, p. 289) explored the question of "how does [rural] place matter [to gain an] ... understanding [of] how geographical issues interface with health care provision or health in places more generally". Influenced by the work of geographers (Cresswell, 1996; Duncan, 2000), Castleden, et al. (2010, p. 285) propose that:

> Place can be usefully conceptualized in two ways: as both physical and social. Connotations of place as a material artefact, a literal location, and a setting for social relations reference its physical nature. Meanwhile, the ways in which people give meanings to places, engage in place-making activities, understand their place, and create emotional attachments to places reference its social nature.

An understanding of rural as place in *both* a physical and social sense is relevant to health practitioners and their work with communities. For example, Chenoweth (2012, p. 97) in discussing young people and their sense of belonging in rural towns suggests that "People and places are connected in complex ways". She further explains that gaining an understanding of these complexities across social spaces, such as land, family, friends and community, is relevant in comprehending why some young people are reluctant to move away from their community for employment. She suggests this can be understood as a breaking of their social attachments with potential emotional implications for them if they do.

2.2.8 Health status of Australian rural populations

Research has shown that those Australians who live in rural or remote regions have poorer health than their urban counterparts (Australian Institute for Health and Welfare [AIHW], 2012a; Bourke, Coffin, Taylor, & Fuller, 2010; Brown & Green, 2009; Commonwealth of Australia: Standing Council on Health, 2012; Dunbar & Peach, 2012; Phillips, 2009). They have higher death rates, predominantly from diseases of the circulatory, cardiovascular and pulmonary systems, as well as dying younger than people in urban areas from motor vehicle accidents (Australian

Institute for Health and Welfare [AIHW], 2012a). Limited access to health services, due to factors of geographical distance or isolation, are also issues of concern for rural populations (Bourke et al., 2010; Bourke, Humphreys, Wakerman, & Taylor, 2012; Phillips, 2009; Pugh & Cheers, 2010; Siaw-Teng & Kilpatrick, 2008; J. Smith, 2007b).

Workforce shortages of health professionals in rural regions which includes family therapists (Bourke et al., 2010; Gregory, 2010; Winterton & Warburton, 2011) and difficulties in recruiting and retaining rural health professionals (Bourke et al., 2012; Brown & Green, 2009; J Humphreys, McGrail, Joyce, Scott, & Kalb, 2012; Keane, Smith, Lincoln, & Fisher, 2011; Maidment & Bay, 2012; Health Workforce Australia [HWA], 2011; Pugh & Cheers, 2010; Sutton, Maybery, & Moore, 2011) are also challenges faced by health services in providing an adequate workforce to meet the health needs of rural populations. The rural health workforces are also older than their urban counterparts, working longer hours than their national colleagues (Health Workforce Australia [HWA], 2011).

Quality of life is a concept that measures a population's wellbeing, such as physical and psychological health, independence and functionality, and socioeconomic conditions (Australian Institute for Health and Welfare [AIHW], 2012a). The majority of Australians (83%) are reported to be satisfied or pleased with their quality of life, while the remaining population are unsure of their feelings (14%) or are unhappy (4%). It is likely that people who are happy with their health status are also more likely to rate their quality of life highly; those who do not rate either of these measures highly are likely to be from disadvantaged socioeconomic populations such as Indigenous peoples and the unemployed (Australian Institute for Health and Welfare [AIHW], 2012a).

Indigenous peoples are more likely to reside in rural or remote regions (Pugh & Cheers, 2010) contributing to the poorer health status in these regions. Indigenous peoples in rural areas have less access to health services and are likely to die 12-17 years earlier than other Australians (Australian Institute for Health and Welfare [AIHW], 2012a; Gregory, 2010) making them a priority population for health services (Bourke et al., 2010; Health Workforce Australia [HWA], 2011).

2.2.9 Mental health status of Australian rural populations

Mental health disorders are experienced by one in five Australians during their lifetime (Australian Institute for Health and Welfare [AIHW], 2012b). Those affected are also likely to have more than one disorder, with the most common combinations being a mental health and physical disorder occurring together. People with mental health disorders experience high levels of disability and psychological distress compared to those who do not experience these disorders (Australian Institute for Health and Welfare [AIHW], 2012a). There are higher rates of mental health problems in rural regions, related to "socioeconomic disadvantage, a harsher natural and social environment, loneliness and isolation, and fewer available health services" (Australian Government, 2011, p. 14).

There are significant differences in emotional distress, mental health and wellbeing of Indigenous Australians compared with non-Indigenous Australians. These differences also include higher rates of confinement for treatment and mortality related to experiencing a mental illness for Indigenous Australians in comparison to non-Indigenous peoples (Australian Institute for Health and Welfare [AIHW], 2012a). Rural Indigenous communities also have high mortality rates generally (Australian Bureau of Statistics [ABS], 2010, 2012a; Rigby, Rosen, Berry, & Hart, 2011). Ongoing drought conditions in 2011 are challenging Indigenous communities as a connection to a healthy land is vital for the communities' holistic wellbeing.

Australian literature includes growing concerns for the mental health and wellbeing of general rural populations in the face of ongoing climatic disasters such as bushfires and drought (Alston, 2011, 2012a, 2012b; Alston & Kent, 2008; Caldwell & Boyd, 2009; Maidment, 2012; McMichael, 2011; Morrissey & Reser, 2007; Rigby et al., 2011). Despite international controversy around whether climate change exists or not, natural disasters such as the Black Saturday bushfires, recognised as "the most serious natural disaster in Australia's history" (Alston, 2011, p. 56), are significantly impacting not only upon the Australian economy but also upon the social context of rural populations (Alston, 2011).

Of particular concern is the mental health and wellbeing of males in rural regions, who are already under considerable stress (Kutek, Turnbull, & Fairweather-Schmidt, 2011). High suicide rates among rural males are a significant health concern (Alston, 2012b; Alston & Kent, 2008; Maidment, 2012; Misan, Lesjak, & Fragar, 2008). Rural males, along with other rural populations, are less likely to use mental health services due to issues of stigma in doing so (Alston, 2012b; Alston & Kent, 2008; Maidment, 2012). Research on rural farming males as a high risk population for suicide suggests males are reluctant to ask for help and indicates this may be linked to men's own understandings of their masculinity (Alston, 2012b; Alston & Kent, 2008). Alston and Kent (2008, p. 144) suggest that, "[Rural] Men's' identity is intrinsically linked to their role as farmers". Therefore in times of adversity, such as the current climatic disasters, rural farming males have, as Alston (2012b, p. 521) proposes, "traditionally adopted a stoic attitude to adversity ... [R]ural masculinity lauds stoicism, rugged individualism and an ability to work through hard times". This 'stoic attitude' may have previously worked for rural farming males but today it is preventing them from accessing help during climatic disasters. It further contributes to an attitude of self blame for farming failures, and is a factor to be considered in the high rural male suicide rates (Alston, 2012b).

While overall suicide rates in Australia have decreased over the last decade, suicide remains an important mental health concern (Australian Bureau of Statistics [ABS], 2012a). Suicide occurs more often in rural regions in comparison to urban regions (Australian Bureau of Statistics [ABS], 2010: 2011a). Unemployment, access to a lethal means of killing oneself, loneliness, and barriers to accessing mental health services have been identified as issues for males with higher deaths rates, including suicide, compared to their urban counter parts (Australian Bureau of Statistics [ABS], 2011a). Rural male farmers have a higher suicide rate than rural non-farming males and Australian males in general (Judd et al., 2006). Recent Australian Bureau of Statistics (2012a) data indicates death rates from suicide are much higher in males compared to females making this the 10th cause of male deaths overall. The highest rates of suicide cited in this data were in the 40-44 year old age group for males and the 45-49 year old age group for females. The most frequent methods used to commit suicide were from hanging, strangulation and suffocation (Australian Bureau of Statistics [ABS], 2012a). Suicide rates for Indigenous peoples are nearly twice

those for Non-Indigenous Australians, especially in males aged between 15-34 years old (Australian Bureau of Statistics [ABS], 2010, 2012a).

2.2.10 Literature review: Part one summary

Part one of this literature review has outlined a broad overview of rural wellness and wellbeing from both international and national perspectives. This includes traditional views of understanding rurality, such as rural definitions, classification systems, demographic data and the health status of rural populations. Alongside these traditional views I have included alternative understandings of rurality such as, social aspects of rurality, Indigenous people's view of wellbeing, gender issues, geography, and understanding rurality as small communities. This diversity of perspectives is useful for exploring more nuanced understandings of rurality and rural practice experiences of myself and participants' during my subsequent analysis.

My purpose in presenting this broad outline is to explore the rural context within which participants of this study are located as rural family therapists. It is important to look at the nature of rurality so practitioners are contextualised working, before moving to the next section of this review below. Within part two of my review I consider, in more detail aspects of rural practice which were significant to my proposed participants.

2.3. Part Two. Practicing in rural communities

I begin Part two of this review with an overview of general practice issues significant to rural practitioners. I then refine my focus to explore practice issues for general rural counsellors and therapists. I finally narrow my focus further to consider practice issues of significance for rural family therapists. By gradually refining my focus I contextualise the place of rural family therapists, as a professional subgroup, within the broader field of rural health, general counselling and therapy practices.

Within this section I also consider the professional backgrounds of my proposed participants and the relevance of these to the literature examined. Participants include those from the health professions of social welfare, social work, nursing (including mental health nursing) and psychology. I focus upon these particular

professions as the issues of rural wellness and wellbeing are relevant in this section of my review to the practices of these professional groups. This is part of my research aim of expanding knowledge of the rural practices of these professionals. However I also included literature which offers professions other than those cited above, where the literature offers significant knowledge relevant to this project about rural practices in professions other than those cited above. This inter-professional focus fits with a family therapy approach and is important for rural family therapy participants in this study. Family therapy theories and skills have been developed across numerous professions and these are discussed in section of my review, as part of a history of family therapy. A significant gap within the literature on rural family therapy is identified.

2.3.1 Generalist practice and ethical issues

Given the limited resources within rural regions, including health services and staff, practitioners are required to be 'generalists' rather than specialists in their practices to meet the diverse needs of clients. The term generalist refers to health practitioners being able to meet a wide range of rural client's needs, rather than specialising in only certain components of a client's concerns (Campbell, Kearns & Patchin, 2006). R. Green (2003) suggests this generalist approach fits well with social work practice and theory, as it meets a rural community's needs by being "compatible with rural life" (p. 210, italics in original). The requirement of practitioners within rural settings to be generalists is acknowledged within international and national literature (Bradley, Werth, Hastings, & Pierce, 2012; Campbell et al., 2006; Chenoweth, 2004; Curtin & Hargrove, 2010; Francis & Mills, 2011; R. Green, 2003; Helbok, 2003; Humphreys, Hegney, Lipscombe, Gregory, & Chater, 2002; Maidment & Bay, 2012; Mills, Birks, & Hegney, 2010; Pugh & Cheers, 2010).

Literature frequently cites the concerns of health practitioners regarding the complexity of the personal and professional relationships they have with their rural clients. By their very nature, rural communities have smaller populations. The details of rural people's lives are often known to many locally, and rural people may also have multiple roles within the same community. This has been likened to living in a 'fishbowl' (L. Roberts, Battaglia, & Epstein, 1999). Literature frequently portrays a

negative view of this lifestyle, and refers to health practitioners living within these 'fishbowls' as being 'visible' or having 'high visibility', as they are readily identified as practitioners which creates a lack of privacy for them (Bradley et al., 2012; Brownlee et al., 2010; Maidment, 2012; Pugh & Cheers, 2010).

Living in a 'fishbowl' also increases the likelihood of health practitioners having multiple roles, both professionally and personally, with clients within their own rural communities. Rural health practitioners:

> not only serve a small community but are often part of the same community. Thus, the rural practitioner is faced with the complications associated with being a professional and person within a rural community, as opposed to being seen by clients only in a professional role, as is the case in larger areas (Bradley et al., 2012, p. 372).

This creates layers of complexity for health practitioners in their development of relationships with community inhabitants, challenging their roles and relationships with clients (Bradley et al., 2012).

As Curtin and Hargrove (2010, p. 559) suggest, health practitioners in rural areas encounter complex relationships that "bleed from the professional to the personal". Health practitioners might know the same person as not only a client but also as their local school teacher, farmer or their own neighbour. The complexity of the professional and personal relationships health practitioners take up within rural communities, and the ethical dilemmas associated with these, is referred to within the literature in terms of dual or multiple relationships or roles (Bradley et al., 2012; Brownlee et al., 2010; Curtin & Hargrove, 2010; R. Green & Gregory, 2004; R. Green, 2003; R. Green, Gregory, & Mason, 2006; Halverson & Brownlee, 2010; Nelson, Pomerantz, Howard, & Bushy, 2007; Pugh & Cheers, 2010; Pugh, 2007; Scopelliti et al., 2004; Turbett, 2009; Werth et al., 2010; Zur, 2006). Some literature suggests dual or multiple relationships are unavoidable in rural regions (Bradley et al., 2012; Pugh, 2007; Scopelliti et al., 2004; Werth et al., 2010).

Alongside and connected to the previously cited issues of the high visibility of health practitioners within their own communities and the multiple relationships they have with clients, rural health practitioners are also faced with ethical complexities in

maintaining client confidentiality in small communities (R. Green, 2003; Pugh & Cheers, 2010; Pugh, 2007; Werth et al., 2010; Zur, 2006). It can be difficult for health practitioners in rural communities to maintain the confidentiality of their clients' interactions, especially when confidentiality may be compromised because of the, "existing networks of knowledge and relationships between people, and by the informal witnessing of contact and association between already known persons" (Pugh & Cheers, 2010, p. 41). Examples of this within literature include: clients recognising each other's cars while visiting rural health practitioners; the likelihood that health practitioners will see their clients outside of professional sessions within their community (Werth et al., 2010); health practitioners being offered information about their clients outside of work practices in social interactions with other community members (R. Green, 2003); and the sharing of information about people's lives and events within local gossip networks (Pugh & Cheers, 2010; Pugh, 2007).

Faced with ethical dilemmas around high visibility, multiple relationships and maintaining confidentiality, rural health practitioners themselves frequently turn to their professional codes of practices for guidance on these matters. These include codes for psychology, nursing, social work, psychiatry and occupational therapy (Bradley, Werth, & Hastings, 2012; R. Green, 2003; Scopelliti et al., 2004; Werth et al., 2010). However there is criticism within the literature of the usefulness for rural health practitioners of any guidelines which are based upon urban based policies, as these may not be relevant to rural contexts (Allan, Ball, & Alston, 2010; Brownlee et al., 2009; R. Green & Gregory, 2004; Humphreys et al., 2002; Werth et al., 2010). Brownlee et al. (2009, p. 631) proposes that "interventions and policies are imported from an urban centre [creating an] ... urban-centric bias".

These authors further suggest that this bias is not necessarily helpful for health practitioners grappling with ethical issues in a rural context, as what is often required is a more sensitive and inclusive recognition and response to the "uniqueness of local communities" (Brownlee et al., 2009, p.631). This provides valuable information and resources into this issue which has potential relevance to other rural practitioners in understanding and working with these ethical complexities and in developing an approach that is ethical, relevant and respectful to rural contexts.

2.3.2 Rural counselling, therapy and family therapy

In the following literature I use the terms counselling and therapy which includes psychotherapy. These terms are frequently used interchangeably in the United Kingdom, Australia and New Zealand. North American usage, in contrast, usually refers to counselling in a psychology or education context, while the term psychotherapy applies to therapy across disciplines (Riessman & Speedy, 2007). The Psychotherapy and Counselling Federation of Australia (PACFA, 2007) reviews professional ethical standards for therapists and counsellors, and uses both the terms counselling and psychotherapy (which includes family therapy) in its title and membership. For the purposes of this literature review I use the terms counselling and therapy synonymously. Where the literature specifically cites a practice, I will also cite it as such, particularly in relation to rural family therapy. I have referred to predominantly westernised literature from North America, the United Kingdom and Australasia in this section of this review, as this was the literature that was predominantly available. I do, however, move to discuss other potential understandings of rurality, from an Australian Indigenous peoples' perspective, in an attempt to be inclusive of non-westernised viewpoints.

In completing this section of my literature review, which examines definitions of counselling, therapy and psychotherapy, and introduces themes and issues from rural counselling, therapy, and rural family therapy literature, I was confronted with a dilemma. On one hand there was a wealth of general literature available across health professions on rural practices which I called upon in part one of this literature review. On the other hand there was a scarcity of specific rural family therapy literature that has also been noted by previous authors (Fetsch & Zimmerman, 1999; Hudgins, 2008; Morris, 2006, 2007). To address this dilemma, I present themes from literature specific to rural counselling, therapy and rural family therapy, much of which is now dated. I have opted to include this dated literature as I believe it still represents issues relevant to current rural family therapy practitioners. For example, issues of a lack of access to professional development opportunities, negotiating geographical distances and navigating the complexities of multiple relationships will be discussed.

2.3.3 Themes from general rural counselling and therapy literature

Mental health, counselling and therapy literature exploring rural practice has predominantly focused on the deficiencies of working rurally and the numerous professional challenges counsellors and therapists face in rural communities (Catalano, 1997; Coll, Kovach, Cutler, & Smith, 2007; Hodgins, Murray, Donoghue, Judd, & Petts, 2004; Jones-Hazledine, McLean, & Hope, 2006; Martin, 2007, 2008; A. Smith, 2003). Low participation in conferences, professional associations and work overload for therapists in rural settings are problems that have been specifically identified (Coll et al., 2007). Similar to rural practitioner concerns presented in part one of this review, the following issues have been identified as significant to rural counsellors and therapists: difficulties recruiting and retaining staff, professional isolation, and a lack of lack access to education and training (Coll et al., 2007; Curtin & Hargrove, 2010; Dorsch, 2000; Hartley, Ziller, Larmbert, Kittyx, & Bird, 2002; Hodgins et al., 2004; Hudgins, 2008).

2.3.4 Rural and urban counselling and therapy practices

There are differences between rural and urban practices for counsellors and therapists (Curtin & Hargrove, 2010; Helbok, 2010; Schank, 2010; Smock, McWey, & Ward, 2006; Werth et al., 2010). Martin (2008) suggests that living in a rural or remote situation makes life difficult, and clinical presentations of families to rural mental health services are often complex. These rural differences have also been described in terms of closeness or connectedness of relationships between people within small communities, including counsellors and therapists (Crago & Crago, 1997). Rural communities are seen as connected to each other and the land they live on (Crago & Crago, 1997; McInnes, 2000).

This rural connectedness provides an opportunity for therapists to work with clients using their own understandings of their lives lived in rural settings (Crago, Sturmey, & Monson, 1996). A.Smith (2003) noted that within this rural connectedness, communities also believe they should be self-sufficient and solve their own problems. This belief may be a barrier to some rural people seeking help for

counselling and therapy. In understanding differences between urban and rural communities, characteristics of 'ruralness' have also included the ability to work hard, being a "hands on" person, and having a willingness to give (Thorngren, 2003, pp. 5-6). These skills of self-sufficiency and creativity that rural people have can be called upon in therapy to empower clients who are experiencing mental health issues as part of rural resiliency (Thorngren, 2003).

American therapy and counselling research has identified statistically significant differences between rural and urban families seeking counselling (Smock et al., 2006). Rural clients were predominantly seeking enrichment of relationships (marital, family, personal or relationship) in their referral for service, while urban clients predominately wanted issues related to parent/child problems addressed. The finding that rural and urban families bring different issues to therapy is informative for the practice of therapists. It allows rural therapists to consider how to address the specific needs of rural families who refer themselves for counselling, and to develop practices inclusive of the rural context within which they and families live and work.

2.3.5 Multiple relationships for counsellors and therapists within rural communities

The issues for rural practitioners of multiple relationships, confidentially and being highly visible within small communities discussed in part one of this review are also relevant to rural therapists and counsellors (Bradley et al., 2012; Curtin & Hargrove, 2010; Halverson & Brownlee, 2010; Helbok, 2010; Schank, 2010; Werth et al., 2010). Rural family therapists also have complex multiple relationships with their clients (Erickson, 2001; Weigel & Baker, 2002), including concerns around confidentiality (Saunders, 1989; Watson & McDonald, 2004; Weigel & Baker, 2002). Despite a prevailing view in the literature that multiple relationships for therapists are problematic, Zur (2006) acknowledges that urban based models of ethics do not always fit the realities of rural therapy settings and practice.

Being a professional therapist in a smaller rural community can mean being well known, highly visible and readily accessible to not only professional clients, but family and friends also (Sigmund & Hodgson, 1995). This accessibility brings ethical

limitations for therapists in considering the confidentiality of clients in rural communities. There are, however, also possibilities of practice referrals for therapists because of their high visibility status. Client referrals may come from those in the community already being seen by a therapist. Such referrals indicate an acceptance of a therapist within their community. Acceptance of therapists within their own rural communities is important to therapeutic work. Bagarozzi (1982) suggests that if therapists are not accepted within their own communities they will not be trusted by clients. To gain this community acceptance, rural therapists need to assimilate into their community in a rurally acceptable way, such as informally meeting the locals at their own locations rather than by traditional urban methods like advertising (Williams, 1975).

James and Hurry (1981) identified further barriers to seeking help by accessing therapy or counselling in exploring the concept of 'high visibility' in rural regions. This concept refers to clients living in rural communities finding that they stood out more, or were more visible, when seeking help compared to those living in larger metropolitan areas. This higher level of visibility, which meant families could be more easily identified within their rural communities when things went wrong, had the potential of increasing their isolation and stigmatisation. Yet equally, rural settings may hide some serious family disorders, due to families' perceptions of their high visibility and potential stigmatisation. When disorders emerge they may cause special problems for therapists (James & Hurry, 1981).

While rural settings create high visibility for clients they also offer opportunities for family therapists to collaborate and network with not only professional counselling and therapy colleagues but also other professional groups, such as the clergy and police in order to lessen feelings of isolation for therapists (Smith, 2003). This collaboration and sharing of knowledge with others is one of the more helpful aspects identified within rural practice (Coll et al., 2007). This need for collaboration and networking across professional groups is demonstrated in research by Fuller & Broadbent (2006) into the role of rural financial counselling advisors. These financial counsellors' roles were mandated to counsel farmers on financial matters only in the wake of persistent drought. However the financial counsellors found that farmers' personal issues were interwoven into the financial issues being discussed which they

were not qualified to address. This was stressful for the counsellors involved. Fuller & Broadbent (2006) suggest the need for professional groups to network together within rural communities, so that they might refer clients to relevant expertise as required.

2.3.6 Impact of climatic adversity on rural communities

The need for counselling and therapy support services for Australian rural communities in general is being exacerbated by ongoing drought conditions and related stresses. Climatic adversities such as drought, flood and fire have a significant impact. In the State of Victoria, bushfires burned for over 50 days in 2007 and again in February 2009, resulting in a significant number of deaths (Australia Associated Press, 2009). This has created ongoing worry, seen as ever present in some rural communities, with Australian researchers suggesting that this stress on rural populations has been underestimated (Morrissey & Reser, 2007). The need for counselling and therapy support for farming and other rural communities could be expected to continue in the face of persistent stresses. Part one of this review presented concerns for the mental health and wellbeing of general rural populations in the face of ongoing climatic disasters such as bushfires and drought (Alston, 2011, 2012a, 2012b; Alston & Kent, 2008; Caldwell & Boyd, 2009; Maidment, 2012; McMichael, 2011; Morrissey & Reser, 2007; Rigby et al., 2011). The role of family therapists and other counselling practitioners are vital to these vulnerable rural communities to support them in these times of climatic and economic adversity.

I now turn to presenting an overview of themes and issues from international and Australian literature specifically about rural family therapy. A significant gap within the literature on this topic is identified by this study. The following sections of this review begin to explore who rural family therapists are and how they are represented (or excluded) within the literature, in order to allow for the development of understandings and potential identities for rural family therapists.

2.3.7 Rural family therapy literature

While family therapy theory and practice have a rich and diverse representation in the literature (Capuzzi & Gross, 2003; Gurman & Messers, 2003), very little has

been written about those family therapists who work in rural regions (Fetsch & Zimmerman, 1999; Hudgins, 2008; Morris, 2006, 2007, 2009; Weigel & Baker, 2002). Similar to other rural practitioners, challenges for rural family therapists include the large geographical distances to be travelled (Hart, 1986; Martin, 2007; Saunders, 1989), the lack of access to professional resources such as supervision and training, and feeling professionally isolated (Crago & Crago, 2002; Hart, 1986; Martin, 2007, 2008; Saunders, 1989; Weigel & Baker, 2002).

Survival for rural families and therapists has been cited as important within the literature. American researchers Jurich and Russell (1987) studied fifteen rural families in financial stress related to the economic downturn in American rural regions in the 1980s. Their results indicated that rural families required more resources from therapists, such as being taught communication skills, and that the families were generally satisfied with their therapy. However farm stresses were so overpowering that they continued to damage families despite their acquisition of new resources from therapists. Jurich and Russell (1987, p. 367) suggest that while family therapy is not a cure all it "may be very necessary to make an intolerable situation liveable". While this research is dated, the results are a useful reminder for current rural therapists to consider potential impacts of the recent global economic downturn (Organisation for Economic Co-operation and Development [OECD], 2012) on the wellbeing of rural families they work with.

For family therapists to survive and sustain themselves, Young (2003) suggests encompassing many points of view and attending to the complexities of families being seen. Saunders (1989) writes of family therapists supporting themselves, through their practice of writing of their love and pride for the country. Crago and Crago (1989) echo this literature, citing the lack of support for rural therapists. They argue therapists in isolation may experience feelings of inferiority, motivating them to be creative in developing supervision to meet their needs (Crago & Crago, 1989).

Interestingly, within the limited literature on rural family therapy, the only specific studies of rural family therapists I found were those from the United States of America (USA) by Morris (2006, 2007). Morris' (2006) pilot survey into the clinical practice and community involvement of American rural marriage and family

therapists noted that there were few research articles on rural marriage and family therapy at the time of the study, and there have been even fewer in recent years. Morris (2006, p. 580) found that the therapists surveyed were of a mature age group, had a range of clinical capacities, worked with diverse populations and contributed to their communities via activities such as professional consultations, volunteer work and serving on local boards. Morris also advocated that further research be conducted using qualitative methodology to find out more about rural therapists and their practice.

In subsequent research by Morris (2007), data was collected from 750 American marriage and family therapists in an attempt to address the gap in knowledge about rural marriage and family therapists and their practice. Morris' findings included the following characteristics of rural marriage and family therapists:

- Rural marriage and family therapists spend more time in conjoint family therapy than non-rural marriage and family therapists
- Rural marriage and family therapists are more likely to possess a master's degree as their highest qualification and are less likely to have a doctoral degree than non-rural marriage and family therapists
- Rural marriage and family therapists are less likely to professionally identify themselves as marriage and family therapists, than non-rural marriage and family therapists
- Gender distribution among rural marriage and family therapists was more balanced than among non-rural marriage and family therapists.

I contacted this author, James Morris (personal communication, 26 June, 2007), to discuss our mutual interest in his quantitative study of rural marriage and family therapists. His study called for more qualitative research to extend the work that he had begun in understanding who rural family therapists are and how they understood issues related to their practice. My choice of a PhD topic of rural family therapy was influenced by the lack of literature on this subject and intends to contribute an Australian perspective to this literature.

Later work by Morris (2009) describes the role of rural marriage and family therapists in his state of Texas. He outlines that marriage and family therapists are a significant presence in this context in relation to other professional groups, such as psychiatrists. In addition, rural marriage and family therapists are one of a core group of five identified mental health professional groups important for the delivery of mental health services and support. Given this, and the current shortage of mental health professionals in rural regions, Morris (2009) proposes that rural marriage and family therapists be included within current American government subsidised Medicare reimbursement systems. He offers that this financial support would allow for increased access by clients to mental health support in rural regions.

Morris' suggestion is supported in other American literature by Hartley et al. (2002). Their report reviewed state laws and the implications of these within the context of mental health workforce shortages in rural regions. This report found that State laws allowed for various professionals to practice, such as social workers, marriage and family therapists, and psychologists. However government reimbursement of fees was limited to only certain professional groups. Their findings and suggestions included that this reimbursement should be extended to relevant core mental health professionals, including marriage and family therapists. Within the Australian context, issues of family therapists (which include those within rural contexts) being reimbursed by national health schemes are still being debated. American literature on rural marriage and family therapists being included within Medicare reimbursement systems provides an interesting comparison for Australian family therapists to consider in their advocacy for similar reimbursements, within Australian rural contexts.

I finish this section of my review of rural family therapy literature by turning to a brief overview of the history of the development of family therapy. I have included this overview to provide a context within which readers may situate family therapists involved in this research project. Family therapists come from a variety of professional groups, calling upon a diverse range of theories to guide their practices. This diversity has relevance in understanding each participant's experiences and practices as a rural family therapist, which is the main aim of this study. I have also called upon family therapy theory and practices in the development of research

processes and analysis with participants, as detailed in Chapter Three. This overview of the history of family therapy provides an introduction to family therapy for those readers who are not familiar with family therapy practices.

2.3.8 A short history of family therapy

Family therapy developed from the general field of psychiatry. It emerged concurrently in a number of regions around the world (Broderick & Schrader, 1981, pp. 8-18) The initial timeframe for this development has been cited as 1952-1961, as 1961 was when all those involved first met and the Family Process Journal began in 1962 (Broderick & Schrader, 1981, p. 18). Literature describing the beginnings of family therapy varies but usually cites Murray Bowen (1978) as one of the "founding fathers of family therapy", who worked with family of origin theory (Efran & Clarfield, 1992, p. 218), and Nathan Ackermann who upon recognising the importance of the social context began seeing clients together with their families (H. Miller, 2001). This first development of family therapy involved a shift from individualist to systemic ways of thinking (Hayes, 1991, pp. 27-28). This was a move away from the 1950s focus on individual interventions with adults only toward including children in family counselling, which then expanded to include an awareness of the relevance of community contexts to the families being seen (Simmons, 2006).

Family therapy moved on from these beginnings to develop into three major schools of thought: structural family therapy, led by Minuchin (Minuchin,1974; Minuchin & Fisman, 1981); strategic family therapy, led by Haley (1976); and systemic family therapy lead by Palazzoli, Boscolo, Prata and Cecchin (1978) (Hayes, 1991). Two different schools of thought related to family therapy began in the United States of America, and one in Milan, Italy (Hayes, 1991). These three schools viewed families as being similar to mechanical systems (Goding, 1992). Therapists attempted to change families by their use of expert instructions to them. While these three schools of family therapy had theoretical differences, there was a sharing and movement of ideas and therapists between the schools (Cantwell, 2001). Family therapy began in the northern hemisphere but the influences of the theories and practices spread internationally. In an Australian context, strategic and systemic schools became the most well known in the 1980s (Hayes, 1991).

Postmodernism was influential in the further development in family therapy through a recognition of the importance of social justice, language, client competencies and narratives. This resulted in the development of collaborative language systems theory (Anderson, 1996; Anderson & Goolishian, 1988), solution focused therapy (de Shazer et al., 1986), and narrative therapy (White & Epston, 1990; Cantwell, 2001). Narrative therapy was developed in Australia and New Zealand by White and Epston (1990) and narrative practices have since been taken up internationally. The shift at this time in family therapy was in the movement of therapists to recognise that families had significant resources *themselves* and to collaborate with them using these resources in therapy practices (Cantwell, 2001; Freedman & Combs, 1996).

Postmodernism's influence on family therapy has also included the work of Michel Foucault (1980) in allowing therapists to recognise the connections between power, knowledge and discourse. This recognition allowed therapists to consider how everyday therapy practices may privilege a chosen discourse and thereby influence clients (Hoffman, 1992). Feminist family therapists (Goldner, 1985b, 1988; Hare-Mustin, 1994) also called attention to the importance of issues of power and gender for therapists, which had not previously been considered. A further shift in family therapy followed, informed by this postmodern critique, where therapists moved away from the neutral positioning of systemic family therapy (Palazzoli et al., 1978) or the emotional distancing of strategic family therapy (Hayes, 1991) towards more collaboratively negotiated practices with families (Freedman & Combs, 1996).

This brief history highlights the development of family therapy and its diversity of theoretical orientations to practice. During its development, family therapy has had significant shifts in theoretical frameworks informed by sociopolitical influences. The more recent influence of postmodern theory has bought about therapies which are more just, being aware of issues of power within therapeutic relationships such as, narrative and solution focussed therapies (de Shazer et al., 1986; Freedman & Combs, 1996; Hoffman, 1992). It is these theories which were most influential within this research project. Both myself and participants as fellow therapists called upon concepts from these theorists to understand our rural practices and experiences.

2.3.9 Current family therapy training

Currently Australian family therapy training includes a diverse range of theories taught in centres nationally. Within this diversity there has been the development of specific therapy schools, such as the Dulwich Centre in Adelaide (Dulwich Centre, 2009) which offers training in narrative therapy. Other centres offer an eclectic mix of family therapy models for practice, allowing therapists to develop their own styles of practice in line with client needs (The Australian Association of Family Therapy [AAFT], 2011b). One example of this approach can be found at the Williams Road Family Therapy Centre in Melbourne (Cantwell & Holmes, 1994).

Australian family therapists, including those cited within this study, continue to come from a range of professional backgrounds. The Australian Association of Family Therapy (The Australian Association of Family Therapy [AAFT], 2011a) is a national family therapy body which has standardised levels of membership, including associate, clinical and lifetime, across Australian states. AAFT is also affiliated with the Psychotherapy and Counselling Federation (PACFA), a national governing body that endorses practice standards and approved training associations for Australian therapists and counsellors (Psychotherapy and Counselling Federation of Australia [PACFA], 2013). A family therapist is currently defined by AAFT as “generally a professional who has been trained and qualified in family therapy” (Australian Association of Family Therapy [AAFT], 2011c, p. 6). Therefore the difference between family therapists and other counsellors and therapists, as defined by AAFT, is in relation to their training in specific family therapy theories and practices. Family therapy training focuses particularly on the whole family as a system for therapy, and frequently involves one or more family members being involved in the therapy.

While there is little in the literature to identify who rural family therapists might be, the present study has highlighted a number of issues relevant to family therapists. These issues are outlined in this literature review and are discussed further in the results chapters which follow. These topics include: rural family therapists understanding rurality from both deficiency and competency perspectives; rural family therapists grappling with issues of intersectionality (racial, cultural and gender differences);

multiple relationships for rural family therapists and what works within rural family therapy training.

2.3.10 Literature review: Part two summary

Part two of this literature review has noted distinctions between the terms counselling, therapy and psychotherapy, and introduced themes and issues for rural counselling and therapy practitioners. These themes and issues include: deficiencies of working rurally for counsellors and therapists; differences between rural and urban counselling and therapy practices; multiple relationships for counsellors and therapists within rural communities; and the impact of climatic adversity on rural communities. Following this, a specific review of rural family therapy literature and a short history of family therapy offered readers a context within which to locate study participants as rural family therapists.

2.4 Chapter summary

This chapter has presented understandings of rurality from both international and national perspectives. It has also outlined issues for practitioners, including complex ethical concerns around multiple relationships within rural settings. A significant gap in the current literature was identified in relation to rural family therapists, which has contributed to the development and direction of this research study, as an increased understanding of rural family therapist's experiences and practices will contribute both to the growing body of Australian rural literature and to the limited specific literature on rural family therapists both here and internationally. To address this gap within the literature and as part of this research project, I now turn to discussing research methodologies in my next chapter. These methodologies created the framework for this project. I engaged with rural family therapy practitioners as part of a participant research strategy, which I now discuss alongside other relevant methodological issues.

Chapter Three

My dinner party discussions with theorists

I organise this chapter in two parts, purposely created to explain theoretical influences on this study and my positioning as an insider feminist researcher. This chapter will begin with the overarching theoretical traditions which inform this research project**.** The theoretical traditions which guided this research project are outlined providing a framework to explore experiences of rural family therapy practice. I discuss my creation of a written account of theoretical frameworks used within this research project. From the work of Kamler and Thomson (2006), a metaphor of a dinner party is introduced which guides both myself and my readers through the complexities of theoretical concepts utilised within this study.

After describing the theoretical traditions that inform this project, I position myself within this research project as an insider feminist researcher. I discuss the main research paradigms of feminism and social constructionism, alongside a participatory action research (PAR) approach which guided this project's construction. Theoretical influences within these paradigms and PAR approach are reviewed in detail, from both a scholarly and feminist personal perspective, to illustrate how these concepts influenced all aspects of this research study.

3.1. Theoretical traditions which inform this research project

The overarching theoretical positions of this study are feminism and social constructionism. A participatory action research strategy shaped the overall project, while approaches in narrative research, narrative therapy and family therapy were also offered to participants to invite them into the research practices. I drew upon theoretical guidelines from narrative thematic, dialogical/performance and visual analysis from Riessman (2008); visual analysis from Pink (2007) within my own analysis in this study.

These theoretical approaches validated a focus on multiple realties, allowing for the complexities of rural family therapy experiences and practices to be explored with participants, while paying attention to issues of power and gender.

3.2 A dinner part metaphor

I drew upon the work of Kamler and Thomson (2006) in the construction of this research account. In teaching doctoral students how to write, Kamler and Thomson (2006) offer a strategy of using a metaphor of the student as host of a dinner party to which they invite chosen theorists as guests. The purpose of this metaphor is to theoretically inform the student's own work from the conversations they have with their chosen guests. Kamler and Thomson (2006) suggest the student maintains the role of a facilitator during the dinner party to guide when guests speak, what they speak of and how often they speak. This allows for the ideas that are developed during these conversations to be retained by students for use in their own writing. Kamler and Thomson (2006) consider "Dialogue is central [to the] text and identity work" (p.88), these students create. This fits with social constructionist theories which frame this research project; that the realities of ourselves and others are socially constructed through using language together (Burr, 2003; Freedman & Combs, 1996; Gergen & Gergen, 2008a).

Adopting the metaphor of the dinner party allowed me to create a fictional conversation space within which I could discuss with chosen theorists the relevance of their ideas to this project. I invited theorists with knowledge of PAR (Reason & Bradbury, 2008), social constructionism (Gergen & Gergen, 2008a, 2008b), and various feminisms (Olesen, 2003, 2005; Reid & Frisby, 2008; Reinharz, 1992), including poststructural feminisms (Davies & Gannon, 2009; St. Pierre, 2000, 2001, 2002; St. Pierre & Pillow, 2000), to be guests at my dinner party. I began as a somewhat nervous host in awe of my chosen guests. Much of the space was taken up with them speaking of their own ideas and me listening within our initial conversations. As the project unfolded I became more able to use my own voice alongside those present. We moved from a formal dinner party to a somewhat raucous and spirited conversational event, debating and challenging each other to provide a space within which differences and diversities could be spoken of. This

allowed for numerous ideas, including contradictions and differences, to sit alongside one another and be heard in subsequent results chapters of this study. I use the following format for my discussions, drawing upon Kamler's dinner party metaphor. I begin by presenting a variety of authors theoretical concepts (the formal part of the dinner party) followed by my own discussion of how I utilised these concepts within this project (the spirited conversational event of the dinner party).

My dinner guests within this chapter speak to me from and through their texts. These are the author's works whom I have read through, alongside and against in coming to understand PAR, social constructionism and feminisms further. These poststructural feminist authors introduced me to the works of Foucault, Derrida and Deleuze.

Within this account I have taken up a concept offered by St. Pierre (2001, p. 146) of learning, "to read one text through another" (p. 146), such as approaching Foucault through reading Butler. I found this concept useful in attempting to understand the complexities of Foucault (1980, 1982; Foucault et al., 1995), Derrida (1982) and Deleuze (Deleuze, 1988; Deleuze & Guattari, 1987) by reading through, with, alongside and at times against other authors (Davies, 2003, 2004, 2005, 2006a, 2006b; Davies et al., 2006; Gannon & Davies, 2007; Gannon, 2010). In reading this way I found myself including the words of these adjunct authors within my own developing text so that their voices might join my own in the telling of this account. Lather (1991, p. 9) describes this postmodern move as one of "*intertextuality*" (emphasis as in original) where I as the author give "a demonstration of how the author is inevitably inscribed in discourse created by others, preceded and surrounded by other texts". This recognises that the inclusion of other authors' voices is an effort to be "multi-voiced" (p.9) while undermining "notions of originality, authenticity and presence" (Solomon-Godeau, 1988, as cited in Lather, 1991, p.9).

3.3 Positioning myself within this research project

This research account is constructed from my own perspective as an insider researcher. In line with poststructural feminist and social constructionist theoretical concepts, I acknowledge that I am inescapably part of the social and historical

contexts within which I live, and within which this account was created (Burr, 2003; Davies, 2004; Gergen & Gergen, 2008a). Therefore within sections 3.3. - 3.5.5, I explore the influence of feminist theories upon research processes and practices utilised with participants during this research project, noting that I come to these discussions as a lifelong feminist. As such, my own experiences and interactions with fellow feminists have influenced the meanings I have made of these theories.

As a poststructurally influenced feminist I am obliged to consider that there are many versions of reality and truth and that mine is not the only legitimate version (Richardson, 2007). In presenting these discussions I am attempting to be transparent to the reader of my own situated position as a feminist author of this project and to present an account which "comes clean" (Lincoln, 2002, p. 333) about my position and stance as the author of this document. I therefore draw upon feminist research principles of researcher transparency and accountability (Etherington, 2007; Reinharz, 1992) during my account of this project. I consider this document as only one of many possible representations of this study. Influenced by the work of Davies (2004) I leave the interpretation of this account to readers once I have written it. I do however hold on to the notion that this research project and account would not have occurred if I had not come up with the initiative to create it, allowing me a sense of authorship for my own contributions as a researcher to this project and thesis.

In 'coming clean' as a feminist researcher, I acknowledge my status as a New Zealand born Australian, and the influence my location within these social and historical contexts brings to this study. I was confronted with difficulties in conceptualising differences of cultural and racial understandings when I moved from New Zealand to live in Australian. As a Pakeha (New Zealand white person), I was exposed to concepts of cultural safety early in my experiences as a nurse (Eckermann et al., 2006; F. Richardson & MacGibbon, 2010). I also grew up involved in Maori culture (Indigenous peoples of New Zealand) and my children have part Ngai Tahu (a South Island Maori tribe) heritage. Aspects of Maori culture were part of my life, and as such I have internalised their importance. Acknowledging my privilege as a Pakeha was an integral part of my previous professional practices with Maori families. Moving to work within an Australian context in the 1990s I was

confronted with a different history of the colonisation of Australian Indigenous peoples and subsequent governmental policies addressing these issues. I struggled with the lack of acknowledgement of the oppression of Indigenous peoples during the initial and ongoing colonisation of Australia. And further, the linkages of this oppression to the marginalised health status of Indigenous peoples, outlined in my literature review. My struggles with these issues influenced this study's preparations. For example, in considering how to move from therapeutic work with Indigenous families to become a researcher in this study, I asked myself, "How was I, as a white, middle-class woman to present the multiple complexities and struggles for dialogue and connection across cultures I and my colleagues experienced with our Indigenous clients? And further, "How would I understand and subsequently analyse any cultural and racial differences in this study that would not marginalise Indigenous peoples further?"

I found myself frozen in my writing and unable to find words to explain the emotional distress I was experiencing in striving to be transparent of my experiences as a white therapist working with Indigenous families. In seeking a way forward I called upon a significant body of feminist theory, which has informed the theoretical development of this thesis (Oelsen, 2003, 2005; 2011; Reid, 2004; Reid & Frisby, 2008; Reid et al., 2006; Reinharz, 1992; Wilkinson, 1999).This body of feminist theory helped me to comprehend my own position of privilege within this research study. Further, these theories identified strategies to counteract my position of power in relation to my participants and our shared positions of privilege as white, westernised middle class family therapists working with marginalised Indigenous families.

3.4 Theoretical influences

I now discuss theoretical influences upon this study within three individual sections. Drawing upon my dinner party discussions with theorists I begin with social constructionist influences, followed by influences from PAR and feminist theories. I present these theoretical influences in this order to reflect how they influenced me in the development of this study. I began as a family therapist familiar with social constructionist theories, who moved to a practitioner researcher role requiring me to develop my knowledge of PAR. Once familiar with PAR I developed a growing

awareness of the importance of issues of power between a researcher and her participants. From this awareness I revisited my early understandings of theoretical concepts from feminisms to update myself on more current theories. From this exploration I was able to identify a way of working with my participants that was respectful, socially just and fitted with theoretical frameworks chosen for this study.

3.4.1 Theoretical influences from social constructionists

Social constructionism views knowledge as communal and located within relationships rather than individual minds (Gergen & Gergen, 2008b). Realties are socially constructed, subject to historical and cultural influences and created daily in our use of language together (Burr, 2003). Scholarly works by Burr (2003), Gergen and Gergen (2008b) and Hoffman (1990) were significant within this study, in that they guided my understanding of social constructionist theory and concepts. For clarity I will firstly explain social constructionism as a theory that is distinct from social constructivism, despite the fact these terms are often considered identical.

Hoffman (1990, pp. 1-3) describes her initial confusion over these terms, thus:

> I assumed that [social] constructivism and social construction theory were synonymous. In both cases the idea of an objectively knowable truth was banished … I [then] realized that the social constructionists place more emphasis on social interpretation and the intersubjective influence of language, family and culture, and much less on the operations of the nervous system [than social constructivists] ... Social construction theory is really a lens about *lenses*.

Gergen and Gergen (2008b, p. 160) suggest a clear distinction between social construction and social constructivism, alongside a rationale for these differences, proposing that social constructionism:

> …typically refers to a tradition of scholarship that traces the origins of knowledge, meaning, or understanding to human relationships. The term *social constructivism* is sometimes used interchangeably but most scholarship associated with constructivism views processes inherent in the individual mind, as opposed to human relationships, as the origins of peoples'

> constructions of the world … [And further that social constructivism has] ... largely been eclipsed by more recent [social constructionist] scholarly developments … [related to more recent political, literary and social critiques of meaning making] (italics as in original).

In sum, Gergen and Gergen (2008b, p. 164) propose that social constructionist theory focuses on language and "relational process" between people rather than "individual minds" as social constructivism does in the construction of meanings and creation of 'realities'.

Relevant also to this study is the theoretical fit of social constructionism with family therapy research (Haene, 2010; Puig, Koro-Ljungberg, & Echevarria-Doan, 2008). My clinical work as a family therapist is influenced greatly by theory and practice learnt at postgraduate level. Social constructionist ways of doing therapy (Andersen, 1987; Anderson & Goolishian, 1992; Cantwell & Holmes, 1994) have made up the majority of my postgraduate diploma study, prior to proceeding to Masters level. This has contributed to social constructionist frameworks being important for my practice as they make up my philosophical stance in therapy and indeed life. Given the importance of these frameworks for my clinical practice, it was to them that I also turned to understanding how to develop research processes and they became influential in the development of this project.

Social constructionism influenced this project in three main ways:

1. Social constructionist ways of teaching and learning within family therapy (Cantwell & Holmes, 1994) were offered to participants as optional research processes during data generation.
2. The approach of Philp, Guy and Lowe (2007) of using social constructionist theory in their supervision with students from other theoretical orientations was informative to this project. Philp, Guy and Lowe (2007) view their supervision as a social construction in itself. This allows them and their students to move to a contextualised position. This facilitates the deconstruction not only of the supervision practices and processes, but of the roles of supervisors and students themselves as they worked together. In this way, ethical issues, including those of power, are made available for consideration from the multiple perspectives of all those

involved. I drew upon the concept of constructing a contextualised position for both myself and participants within our data generation processes.

3. I drew upon the work of social constructionists Gergen and Gergen (2008b) to endorse the valuing of multiple perspectives in action research. Gergen and Gergen (2008b) use the term “polyvocal agent” (p. 168) in relation to researchers involved in the pursuit of multiple meanings and realties. I found this term to be a useful one for this research project, as it described the researcher role that I took up with participants. I also found Gergen and Gergen’s (2008b) notion of acknowledging previous research contributions to current research knowledges *within current projects* valuable as an ethical position. By acknowledging previous practice and research contributions to current family therapy practices I was able to offer participants an alternative view of differences in therapy. Viewing difference as part of the overall historical development (Goding, 1992) of family therapy allowed for the work of those who have gone before to be acknowledged as contributing towards current models of practice. I found that this alternative view of differences as historical development was a helpful means of addressing potential dilemmas with participants around their diversities of therapeutical theory and practices. Acknowledging the work of previous others also allowed me to “credit the process of collaboration that is so central to action research itself” (Gergen & Gergen, 2008b, p. 169).

As a researcher within this project, I found social constructionist literature supported me in considering multiple and diverse views of reality (Gergen & Gergen, 2008b). I was also guided by this literature to invite in voices of diversity and difference in order to become a “polyvocal agent” (Gergen & Gergen, 2008b, p. 168). In attempting to achieve this within this project I encouraged multiple views and dialogue about differences with participants by engaging in “reflexive conversations, in which a person makes her prior conversation an object of her own observation, one shifts the discourse and thus perspective” (Lax, 1992, p. 75). These reflexive conversations also fit with family therapy reflecting team approaches which were offered as an optional collaborative data analysis approach with participants, as outlined in part three of this chapter.

I adopted a contextualised position within this research by being a “polyvocal agent” (Gergen & Gergen, 2008b, p. 168). This allowed for the deconstruction of the research processes, practices and role a researcher of this project. This contextualised positioning was made transparent to participants and was also offered as an optional position they could also adopt if they chose to do so during analysis. Im addition, I used questions from the Public Conversation Project (Herzig & Chasin, 2006) to facilitate contextualised positioning and dialogue across diversities and differences within this project.

My intention in taking up these practices was to make room and invite in all theoretical orientations of participants, maintaining an ethic of openness towards differences in rural therapy practice within this research project. My hope was that this ethical openness would support my recognition of multiple views of reality, aligned with social construction theory (Burr, 2003; Gergen & Gergen, 2008a, 2008b). I also attempted to validate each participant while making visible the different knowledge bases they hold. I remained mindful at all times that my actions in this research were to be aligned with PAR practices, and to be of benefit to participants rather than researchers (Reason & Bradbury, 2008).

In this spirit of PAR I strived towards creating a space where different theoretical orientations were able to be understood and respected by participants. Rather than drawing resources away from participants I sought to contribute towards the understanding and knowledge of participants and their communities around rural family therapy. I believed this to be an ethical position, honouring the participants’ choices while providing a richness of diversity to the project, informed by the collaborative research relationships that developed. In Chapter Four, I outline my work with Gippsland focus group participants in attempting to maintain an ethic of openness with them to allow them to speak of diversities and differences within the families they worked with.

The social constructionist perspective of my research project thus creates the research process itself as a sociopolitical and sociocultural event, offering me a position to engage in “facilitation of transformative, interactive, and dialogical practices” (Etherington, 2007, p. 442).

3.4.2 Theoretical influences from PAR and Feminisms

In addition to social constructionist theoretical influences, I utilised a PAR strategy and influences from feminism within this project.

3.4.3 Participatory Action Research

Participatory Action Research (PAR) develops new living knowledges and understandings through collaboration, reflection and conversations with participants (Reason & Bradbury, 2008). PAR is inquiry "done *by* or *with* insiders to an organization or community, but never *to* or *on* them" (Herr & Anderson, 2005, p. 3). This practice includes participants negotiating issues of importance to them in the research, including the sense they make of research questions (Reason & Bradbury, 2008). I chose a PAR strategy because of its emphasis on reducing research hierarchies through processes that are collaboratively negotiated. My engagements with participants are from social constructionist and feminist research perspectives (Gergen & Gergen, 2008a; Reinharz, 1992). The notion of collaborative negotiation with clients is an important one to me as a family therapist. My therapeutic work includes narrative therapy (White, 2007; White & Epston, 1990) which is theoretically influenced by both social constructionist and feminist theories. Significant for me also is that narrative therapy has a social justice agenda which a PAR strategy allowed me to enact in my relationship with participants.

PAR frequently endeavours to challenge and transform social inequalities and oppressions (Herr & Anderson, 2005) by valuing democracy and participation (Reason, 2006). Emancipatory PAR is an inherently political process as it seeks to empower communities, often marginalised groups (Herr & Anderson, 2005; Lykes & Mallona, 2008). Self-reflective cycles of planning, action and reflection through an "action research spiral" (Kemmis & McTaggart, 2005, pp. 563-68) guide the research process (Herr & Anderson, 2005; Reason & Bradbury, 2008). The creation of knowledges that are practical to everyday lives are valued in PAR which also seeks to contribute to the wider wellbeing of people and the communities of which we are all a part (Reason & Bradbury, 2008). As an insider to this research I specifically chose an emancipatory PAR strategy because of the contribution in practicality it

brought to rural family therapists and their communities. One hope I held for this research project was that understandings created together with participants would be shared as feedback with them at the completion of this project. This would allow them access to communally created concepts which individual practitioners struggled with, such as understandings of cultural differences in working with Indigenous families.

PAR allowed me to be a researcher, facilitator and co-participant in research processes, with an understanding that I had particular knowledge to contribute to the participants (Kemmis & McTaggart, 2005, p. 594). I was both a practitioner-researcher and participant within this research project. This privilege allowed me to move between these two positions, reflecting and asking questions of participants and of my own therapy practice, while remaining transparent and accountable about my positioning as a researcher.

Frequently PAR researchers are also insiders to the research, being inspired by a professional interest requiring reflexivity in the research processes with participants (Herr & Anderson, 2005). This PAR interest in being an insider researcher is shared also by feminist researchers (Vickers, 2002). My interest in both a PAR strategy and feminist theories lead me to the work of Reid and Frisbee (2008), who brought these two influences together in what they called feminist participant action research (FPAR). A FPAR approach aligns the two important theoretical approaches of PAR and feminisms used within this project.

3.4.4 Feminist theoretical influences

> Knowing that we do not know is knowledge. And further, knowing that what one thought one knew is no longer believable is the most significant form of knowing (Sosnoski, 1989, p.34).

3.4.4.1 Feminisms: A short situated history

The historical development of feminisms has been described as a series of ‘waves’ (Donovan, 2012; Hannam, 2012; Jaggar, 1983; Oelsen, 2003). While there have been criticisms of this metaphor, it continues to be used to describe feminisms’ historical development by many authors (Donovan, 2012). One author suggests the

focus is less on which wave feminists are within. Rather it is focusing on making required changes that is important: “Never mind which wave we are on, we need to be making more waves” (Spencer, 2004, as cited in Donovan, 2012, p.12).

While there is no one, simple overarching theory of western feminism (Frisby, Maguire, & Reid, 2009, pp. 249-257; Gannon & Davies, 2007; Hannam, 2012; Hesse-Biber, 2007; Reid, 2004), a shared belief amongst feminists is that “the oppression of women is a fact of life” (Warhol & Herndl, 1997, p. x). According to Flax (1993, pp. 81-82), a “series of assumptions” shared by feminists’ underlines the following beliefs:

> Men and women have different experiences; the world is not the same for men and women ... [W]omen’s oppression is a unique constellation of social problems to be understood in it ... [O]ppression of women is part of the way the world is organized and that one task of feminist theory is to explain how and why this structure [of patriarchy] evolved ... ‘Patriarchy’ is the system in which men have more power than women.

Collective goals of feminist theorists include trying to understand and overcome this oppression (Flax, 1993). While these beliefs exist across feminist theories, so do theoretical differences (Jaggar, 1983; Olesen, 2005). Warhol and Herndl (1997, p.*x*) suggest many critics have misunderstood feminist thought, as there is not “a single “feminist” critical perspective”, rather there are multiple, diverse theories relevant for a number of purposes. This has led to suggestions of using the term ‘feminisms’ (rather than ‘feminism’) to acknowledge the theoretical diversity in addressing women’s oppression (Donovan, 2012; Reid et al., 2006).

I have chosen to use the term ‘feminisms’ within this research account in an effort to acknowledge the diversity of ideas both past and present within feminist theories, in line with previously cited authors. I present within this short history only the significant aspects of feminist theories which are relevant to this project.

3.4.4.2 Waves of feminisms

Third ‘wave’ feminisms are the most relevant for my study. They are suggested as beginning from the 1980s and 1990s onwards and tend to focus on achieving sociopolitical change and critiquing the deficits of previous feminist theories (Oelsen, 2003). These critiques include challenging the “privileging [of] white, western, middle-class, heterosexual women’s perspectives” (Reid et al., 2006, p. 18) in relation to issues of importance for feminists. From these critiques, women’s voices from previously marginalised positions began to be heard. These voices included black feminist theorists, lesbian and queer feminist theorists, feminist Marxist theorists (Reid et al., 2006), postcolonial feminists and postmodern feminists (Olesen, 2005). Reid et al. (2006, p. 18) describe feminists of this time as beginning “to focus much more on the differences than on the similarities between women”.

Donovan (2012) suggests we are currently within a fourth ‘wave’ of feminisms, namely global feminisms and eco-feminisms influenced by poststructural and postmodern theories. Global feminisms focus on “the condition of women in the non-western world”, while eco-feminism is “concerned with the connections between male-domination and the despoliation of the natural world” (Donovan, 2012, p. 184). These new developments and perspectives illustrate a broadening of the earlier focus of liberal feminisms on individual rights and equality with men to a move that considers a global view of feminisms and the impact of worldwide patriarchal issues upon the lives of women and communities.

Perspectives from feminists such as those cited above have “upended taken for granted conceptualizations of feminist research as well as critical key concepts such as experience, difference and gender” (Olesen, 2005, p. 248). In this view, the roles of feminist researchers themselves came under scrutiny. This included consideration of the multiple positions and issues for feminist researchers who were taking part in their own research endeavours through being ‘insider’ researchers (Vickers, 2002). Also considered were ethical issues of how being an ‘insider’ researcher impacted upon participants and the research processes themselves (Olesen, 2005, pp. 249-257). Reinharz’s (1992) influential work called attention to the multiple relationships between a researcher and those she researches, suggesting the value of this

approach. Feminist qualitative research became more intricate, as Oelsen describes (2003), “boundaries between researcher and the researched … became blurred” (pp. 353-367). Consideration was given to not only traditional feminists’ concerns of women’s experiences, but also to the social and historical contexts within which women’s lives were located (Oelsen, 2003).

Also emerging during the third ‘wave’ of feminisms was intersectionality theory. Which was of importance to feminists because of its focus on multiple understandings of women’s positions across racial, cultural and gender differences. Intersectionality theory was described as:

> the interaction between gender, race and other categories of difference in individual lives, social practices, institutional arrangements, and cultural ideologies, and the outcomes of these interactions in terms of power (Davis, 2008, p. 68).

Whose voice is heard within the research accounts – that of the researcher or those of the participants she is researching – became an important ethical issue for feminist researchers (Fine, Weis, & Wong, 2003). Somewhat ironically, this led feminist researchers back to early feminists’ aspirations of finding a voice for women to speak of their experiences (Oelsen, 2003) and an audience to listen to them while they do so. The notion of a feminist researcher not being separate from her data, nor expecting to be, became part of feminist discussions, influenced by postmodern and poststructural theories.

3.4.4 3 Reviewing initial feminist research principles

As a rural family therapist myself I was inevitably personally as well as professionally involved in the research process. Being involved in “insider research” (Vickers, 2002, p. 612), where I was part of the group being studied, allowed “insights into process, phenomena, and individual, cultural, or group dynamics that others cannot witness” (p. 619) to emerge. Olesen (2005), in reviewing the development of feminist research and a researcher’s use of self within research process, suggests this practice is useful, if the researcher is able to be reflexive.

I engaged in reflexivity and an ongoing self-critique of my own practice, research processes and the theoretical frameworks chosen for this research. I called upon feminist researchers to define reflexivity within this project as “attempting to make explicit the power relations and the exercise of power in the research process” (Reid & Frisby, 2008, p. 100). By engaging with practices of reflexivity I was attempting to achieve multiple positions for myself, both inside and outside of this research project, to facilitate different understandings for participants and myself of the research topic (Hesse-Biber & Piatelli, 2007).

I built transparency and accountability processes within this research project to address ethical dilemmas around concerns of researcher responsibilities and power related to research processes. These processes included:

1. A statement of my own hopes and intentions for this project, including my theoretical orientation, in the invitations I issued for participants to be interviewed (Appendix E).
2. Holding pre-research meetings or discussions with participants, prior to the individual interviews, small groups or focus groups commencing, with the specific intention of cultivating relational ethics (Ellis, 2007) with participants to explore any potential ethical dilemmas and thus develop an ethical framework for our work together
3. Developing what qualitative researchers call reflexive relational ethics (Etherington, 2007) or relational ethics (Ellis, 2007, p. 3), which require “researchers to act from our hearts and minds, acknowledge our interpersonal bonds to others, and take responsibility for actions and their consequences”.
4. Drawing upon feminist and social constructionist theories (Gergen & Gergen, 2008a; Hesse-Biber, 2007) to develop my own reflexive researcher questions so I could provide a socially just direction in beginning research conversations with participants.
4. Offering optional cumulative research processes, based upon reflecting practices from family therapy, to participants to allow for their own experiences as therapists to be drawn upon as part of a PAR strategy.

Despite creating and following these strategies, I do acknowledge that I shaped this research even while attempting to engage collaboratively with participants to

minimise my influence on the research processes. This shaping was informed from my social constructionist and feminist research paradigms which called attention to issues of power and gender (Olesen, 2005; Reinharz, 1992; Swan, 1999; Wilkinson, 1999). I also acknowledge that while I attempted to address issues of power in my relationship with participants during this research, I remained in a dominant [or privileged] position throughout. Power is, inevitably, a "fact of everyday discourse and life "(Larner, 1999, p. 40). One example of this was the inherent power I claimed in organising and facilitating research meetings. As a researcher I used my chosen theoretical positioning to inform this project and was therefore not neutral in my actions. These ethical issues required me to be transparent and accountable to participants and I attempted to do so by making issues of power, gender and ethnicity visible and open to discussion with participants.

3.4.4 4 Emotionality and visual materials

Feminist theories also called my attention to the usefulness of the emotions of participants, as part of my data analysis, alongside a PAR research strategy (Kemmis & McTaggart, 2005; Reason & Bradbury, 2008; Herr & Anderson, 2005), narrative analysis (Riessman, 2008), and visual analysis (Riessman, 2008; Pink, 2007). Jaggar (1989, p. 151) proposes that emotions play "a vital role ... in the construction of knowledge", while Hesse-Biber and Piatelli (2007) suggest we respect emotions of researchers in the field and value emotionality within relationships with participants to support insights into the research itself. More recent literature by Holmes (2010) supports this view, highlighting the important role emotions play in processes of reflexivity.

Within this project I analysed data generated with participants in written (transcripts) and visual (DVD) forms, created within PAR processes to gain different understandings of participants' communications (Pink, 2007; Riessman, 2008). The emotionality of participants was an important aspect of my analysis and is discussed further within Chapter Four.

3.4.4.5 Poststructural feminisms

Feminist poststructuralism allows for new explorations of women , where they are:" not Woman as the complementary and spectacular other of man but rather a complex and multi-layered embodied subject who has taken her distance from the institution of femininity ... a subject-in-process" (Braidotti, 2002, as cited in Hesse-Biber, 2007, p. 100).

While early feminist theorists introduced me to initial understandings of power and patriarchy, it has been poststructural feminists (Davies, 2003, 2004, 2005, 2006a, 2006b; Davies et al., 2006; Davies & Gannon, 2009; Gannon & Davies, 2007; Lather, 1991; St. Pierre, 2001, 2002; St. Pierre & Pillow, 2000; St. Pierre, 2000; Swan, 1999) who have extended my understandings of power, subjectivity and concepts of realities further, in their introduction to me of French philosophers Michel Foucault, Jacques Derrida and Giles Deleuze. As I read alongside, through, and against their poststructural texts I came to new understandings of power and resistance from poststructural feminist critiques of Foucault's work on these subjects (Butler, 2004; Gannon & Davies, 2007; Lather, 1991; St. Pierre, 2001; St. Pierre & Pillow, 2000; St. Pierre, 2000). From reading Derrida through poststructural feminists (Davies et al., 2006 ; Lather, 1991; St. Pierre, 2000) I came to the understandings of deconstruction and erasure used in my analysis, discussed in sections below.

Reading Deleuze through Davies (2004) and Gannon (Davies & Gannon, 2009) led me to ideas of transformation and change; new lines of flight (Davies & Gannon, 2009), that I return to in my analysis. I was also able to move forward into reading the translated works of these French philosophers (Deleuze, 1988, 1995; Giles Deleuze & F Guattari, 1987; Derrida, 1982; Foucault, 1980, 1982; Foucault, Stastny, & Åžengel, 1995) on my own, once introduced to them by poststructural feminist authors cited above. From my familiarity of these French philosophers' works, I chose theoretical concepts useful for my analysis to discuss together during our dinner party conversations.

Like other feminisms, poststructural feminisms are difficult to define. Many authors have theoretical differences, so the following descriptions are not meant as definitive

understandings or finalised meanings of poststructural feminisms. Rather these theories remain unfinished, always a work in progress because of the very nature of the theoretical concepts they embrace. As Davies et al. (2006, p. 100) propose, “The work of feminist poststructuralism is, by definition, work that it can never complete”.

Reinharz (1992) suggests when seeking definitions of feminist research to look at the explanations provided by those involved in the process. This suggestion has since been utilised by poststructural feminists in order to allow participants to self-define research activities (St. Pierre & Pillow). In this section on poststructural feminisms, I am calling upon fellow researchers and authors for their explanations of these terms, which I then translate into this research project with participants. I present past and present works by these authors that have shaped this project, so as to provide an historical overview of how poststructural feminisms have changed over time. I do this influenced by a Foucauldian practice of problematisations (Neal, 2009), which asks how a problem “became a problem historically” (Neal, 2009, p. 167). This approach also considers sociopolitical and historical contexts of problems which I discuss in subsequent sections.

Weedon (1987, p. 130-131) argues that liberal and radical feminist theories have been “politically inadequate” in their attempts to define “Women’s nature once and for all ... [And these theories] do not engage politically with the complex power relations of particular patriarchal sites”. This view is also supported within more recent literature (Gannon & Davies, 2007). Weedon (1987, p. 121) proposes that:

> the subject [woman] in poststructuralism is socially constructed in discursive practices; she none the less exists as a thinking, feeling subject and social agent, capable of resistance and ... [being] able to choose from the options available.

She further asserts that an understanding of power is important to poststructural feminists to address the inadequacies of previous feminist theories:

> Postructural feminism requires attention to historical specificity in the production, for women, of subject positions and modes of femininity and their place in the overall network of social power relations (Weedon, 1987, p. 131).

Alternatively, it has been suggested in more recent literature that poststructuralism is "another manifestation of feminism with its own political agenda" (St. Pierre & Pillow, 2000, p. 506) and that there is common ground between feminisms and poststructural theories in their understandings of the everyday lives of women. The relationship between these two theories has been described as "invigorating and fruitful" (St. Pierre, 2000, p.2). Also supportive of a political view of poststructuralism feminism is Lather (1991, p. 89), who suggests that this approach is:

> [a] preoccupation with the politics of knowing and being known ... it is the discursive formations of inquiry, [of] the system of norms or rules that govern a certain way of thinking and writing at a certain time and place.

It has been suggested that the combination of liberal and postructural feminisms allowed an opportunity for feminist researchers to consider how we might do research differently, exploring our own roles as researchers and of the knowledge created, wherein:

> the feminist qualitative researcher can make her own slippery subjectivity, power interests, and limitations–the recognition that her knowledge production is partial, contextual, and inevitably flawed (Richardson, 2007, p. 459).

There has also been some agreement by feminists that poststructural methods offer "critiques and methods for examining the functions and effects of any structure or grid of regularity that we put in place, including those poststructuralism itself might create" (St. Pierre & Pillow, 2000, p. 6).

We are reminded by Richardson (2007) that poststructuralism offers feminists a defiant attitude towards accepting what is offered as the truth; that our words, ourselves and even the theories we embrace have no claim to being the only reality. In this view:

> Feminist-poststructural theory holds that no theory or method has a corner on the truth. No writing is innocent. Power, language, and subjectivity are intertwined; the self is fluid; and knowledge is local, partial, and contextual (Richardson, 2007, p. 459).

The terms postmodern and poststructuralism are frequently seen as similar, (Gannon & Davies, 2007; St. Pierre, 2000). However, the poststructural term has

been more commonly used recently and “signals in particular the ‘linguistic turn’ [and this] turn to language ... is a recognition of the constitutive power of language, particularly as introduced through the work of Michel Foucault” (Gannon & Davies, 2007, p. 80). I discuss this in the following sections. I found the following description a useful précis of postmodern theoretical influences, in relation to understanding knowledge and ways of knowing, that I held in mind while undertaking a written account of this research project:

> The core of postmodernism is the doubt that any method or theory, discourse or genre, tradition or novelty, has a universal and general claim as the “right” or the privileged form of authoritative knowledge (St. Pierre, 2000, p. 499).

The influence of poststructuralist feminist theories was significant to me as author of this project in that they allowed me to come to an understanding that “no [one] theory or method has a corner on the truth” (Richardson, 2007, p. 459) or is the only, “‘right’ or the privileged form of authoritative knowledge” (St. Pierre, 2000, p. 499). Alongside this introduction I took up St. Pierre’s (2001, p. 146) invitation to “read “strategically” so that I read with, alongside and against other authors coming to an understanding of the works of these French philosophers. These understandings are discussed in the following sections for their relevance to this project’s analysis and discussions.

My dinner party discussions with these theorists gave me permission as a feminist researcher to include my own understandings and “embodied” (Davies, 2004, p. 4) knowledge within this project, enabling me to write these into the text of this account. I was also given permission to bring forth my own assumptions and ideas that informed this project (Agger, 1991). I do so with the purpose of examining them using practices of deconstructionism from the work of Derrida (Caputo, 1997; Davies et al., 2006; St. Pierre, 2000). I also found myself able to join my voice to other feminists in thinking differently about research practices, and seeing writing as a way of knowing (Richardson, 1994; St. Pierre, 2001). The work of the poststructuralist feminist “entails a politics and practice of writing differently. It is through writing differently that thinking differently becomes possible” (Gannon & Davies, 2007, p. 97). This allows me also to travel differently within the contours of feminist research,

moving towards my own space of change, transformation and becoming (Davies, 2004; Davies & Gannon, 2009) as a researcher.

3.5 Influences of French philosophers: Foucault, Derrida and Deleuze

The influence of French philosophers Gilles Deleuze, Felix Guattari, Jacques Derrida and Michel Foucault has been important for poststructural feminists such as, Butler, (2004); Davies (2004, 2006a) ; Davies & Gannon, 2009; Lather, (1991, 2001); and St. Pierre (2001) and is significant to my own analysis. As I "strategically" (St. Pierre, 2001, p. 146) read these French philosophers works, I purposely chose aspects of their theoretical concepts for use within my results chapters to further analyse dominant understandings of rurality. I now introduce my own understandings of these French theorists theoretical concepts of power and resistance, erasure, deconstruction, transformation and change which I utilise within my analysis. I drew most extensively upon the work of Foucault (1980, 1982; Foucault et al., 1995) and therefore begin by outlining my understanding of his concepts in more detail below. I also include feminist critiques of Foucault's work, given the significance of his work to this analysis and the inclusion of his concepts within a feminist research project.

3.5.1 Foucault

Foucault has been recognised as "one of the giant intellectuals of the 20th century" (Denzin & Lincoln, 2005, p. 647). His work has been "influential in almost every area of humanities and social sciences" (Neal, 2009, p. 161) over the last two decades, including, significantly for me as a family therapist, the development of narrative therapy (Besley & Edwards, 2005). Foucault's work occurred during a time of a turn to the "linguistic", whereby "the constitutive power of language and of discourse ... [became the focus for poststructuralists and included, "[a] ... shift of interpretive focus from language as a tool for describing real worlds to discourse, as constitutive of those worlds" (Gannon & Davies, 2007, pp. 80-81). Poststructural feminists have found Foucault's work on power useful for their purposes, such as in Butler's (2004) critique of the relationships of bodies and power. Foucault's understandings of "the relationship of knowledge, truth, and power and his analytical methods, archaeology

and genealogy, have [also] been put to good use by post structural feminists in their work" (St. Pierre, 2000, pp. 493-499).

3.5.2 Feminist critiques of Foucault

While one group of feminists have accepted Foucault's work as useful to feminisms' goals, there are also criticisms from other feminists sectors as to the relevance of his work. These criticisms include those from Ramazanoglu (1993, pp. 12-16) who argues that Foucault does not consider power from:

> the perspective of women's experiences... how it feels to be subordinated ... Feminists need to go beyond Foucault's analysis of power, by hanging on to radical feminism's sense of moral outrage, while modifying this with recognition of the diversity of women's conditions of life.

Further critiques suggest that while Foucault's work is relevant for feminists, his concepts of relations of power require gender to also be included (Amigot & Pujal, 2009).

Other feminists have promoted the usefulness of Foucault's works to the cause of feminisms (McNay, 1992; Swan, 1999). These particularly include his work on governmentality (Macleod & Durrheim, 2002) and his focus on the complexities of understandings of power as relevant to feminists (Ellis, 2003). Some also argue that Foucault's later work should be 'embraced' by feminists as it fits with the 'the personal is political' agenda of feminisms, offering feminists opportunities for self-transformation (McLaren, 2004). Whatever their view, "Feminists cannot afford to ignore Foucault" (Ramazanoglu, 1993, p. 3).

3.5.3 Foucauldian influences upon my analysis

Within this project I chose to call upon feminist critiques of Foucault's work which considered the usefulness of his work to feminisms' goals. These critiques included that of McWhorter (2004), who viewed Foucault's philosophy as a way of living, a pursuit to:

> take care of myself ... [and in relation to the work of] Foucault, philosophy is not a body of ... analytical techniques. It is a way of living, a pursuit that informs all our activities ... that it is a kind of creative self-shaping, a kind of

> self-transformation that opens towards differing, toward the unmastered and the unknown (pp. 146-159).

I found myself in agreement with McWhorter's (2004) cited understandings of the usefulness of Foucault's work to feminists and also with poststructural feminist St. Pierre's (2001, p. 493) critiques of Foucault's work which "found these theories of power, resistance, and freedom useful in their work for social justice". I too found Foucault's work useful in understanding power issues between participants and their families as clients, alongside my understandings of power with families in my own therapeutic practices.

Foucault's work influenced the development of narrative therapy which shares feminisms' goals of "ending patriarchy and liberating women" (Swan, 1999, pp. 104-111). Narrative therapy practices alongside other therapeutic approaches which consider the socio-political context (Anderson & Goolishian, 1988; Goldner, 1985b; Hoffman, 1990, 1992; Lax, 1992; Madigan, 1999; White & Epston, 1990) are relevant to me as a feminist family therapist as they allow me to appreciate the wider socio-political contexts within which families experiencing difficulties find themselves embedded and which may lead them to seek therapy.

Therapeutic approaches which explore the problems families bring to therapy in relation to wider socio-political contexts, such as narrative therapy, were instrumental in the development of this research project, as outlined in Chapter One. The importance of these therapeutic approaches for me as a practitioner was in the opportunities they offered to pursue a social justice agenda with families, in reconsidering their relationships to the concerns they bought to therapy and wider socio-political contexts. Foucault's (1980) concept of 'power/knowledge' also allowed me to pursue a social justice agenda within this project as part of a layered approach to analysis. My results chapters five to ten utilise Foucault's (1980) concepts of power and resistances to this, normalising practices (Foucault,1982; Neal, 2009; McLaren, 2004), subjectification and problemisation (Neal, 2009) to further analyse participants' stories of resistances to dominant understandings of rurality and the impact of these upon their practices.

I use Foucault's concept of problematisations not only to analyse data generated with participants, but also in an analysis of myself as a researcher and my understandings of theories and concepts used within this project. Instead of a "problem solving methodology ... Foucault looks at *problematizations* [sic] in history ... [and] asks how ... [a problem] became a problem historically ... considering social, political and historical thought" (Neal, 2009, p. 167). I used Foucault's concept of problematisations, during my analysis to ask myself questions of how dominant understandings of rurality came to be, within participants' stories. This created a pathway for me into analysing dominant understandings of rurality differently, allowing for alternative understandings to emerge.

3.5.4 Derridan influences upon my analysis

Alongside Foucault, the works of Derrida (as cited in Hepburn, 1999) on erasure and deconstruction are significant to me within this project. These theoretical concepts offer me guidance for my analysis in conceptualising alternative understandings of rurality. To understand the use of the concept of erasure, I read Derrida's work through Davies (2006 et al., p. 100) who suggests:

> Poststructuralist theory provides a set of theoretical propositions that attempt to articulate the ongoing process of being subjected, of subjectivity, of the relations between the outer and the inner, of the constitutive force of discourse. The individual as an observable, describable object (and product) of the scientific gaze, which exists independent of any description of it, is put under erasure.

I also read Lather's (1991) text on how to utilise this poststructural strategy. Lather (1991, p. 10), citing the work of Derrida, suggests writing "under erasure" means for her "to write paradoxically aware of one's complicity in that which one critiques. Such a movement of reflexivity and historicity at once inscribes and subverts". Using this poststructural concept, I sought out the contradictions and discrepancies within my own understanding of theories used in this project, including my analysis. I also created my own reflective researcher questions in an effort to deconstruct my research practices as I developed them with participants.

In attempting to come to my own understanding of the Derridean concept of deconstruction for use within this project and my analysis, I again initially read Derrida's theories through other authors (Caputo, 1997; Davies et al., 2006; Morss & Nichterlein, 1999; St. Pierre, 2000), before attempting to read Derrida's own translated text (Derrida, 1982). I came to appreciate the difficulties in any definitions of deconstructionism, as the purpose of this concept is to defy any such definition (Caputo, 1997). As Derrida himself suggested when persuaded into giving a succinct definition of deconstruction, it is an "experience [and pursuit] of the impossible" (cited in Caputo, 1997, p. 32).

Despite the complexities in defining deconstruction, I found Davies et al.'s (2006, p. 99) understanding of this concept as "the name we give to the critical analytic work through which relations of power and the constitutive force of discourse is made visible" useful for this project. By reading Derrida through St. Pierre (2000, p. 482), I came to know deconstruction also as an affirmative practice rather than a destructive one. Deconstruction in this view is "not about tearing down but about rebuilding" (St. Pierre, 2000, p.482). Also useful to me is an alternative understanding of deconstruction offered by Morss and Nichterlein (1999, p. 165) as being a process of "unsettling, a disturbing [of understandings]". For me, these understandings of deconstruction led to an appreciation of being both an insider and outsider in this project, as a feminist therapist and a researcher. Further, I came to see that this positioning was both desirable and possible, in its creation of opportunities for an exploration of disturbed understandings within my data analysis.

Deconstructive approaches likewise authorised me to disturb understandings of participants' experiences of therapeutic practices with Indigenous peoples. This allowed for alternative understandings of potential therapeutic work with Indigenous peoples to emerge, alongside previously undisturbed understandings offered by participants. Both 'disturbed' and 'undisturbed' versions were able to sit alongside each other. The original undisturbed versions did not need to be destroyed (St. Pierre, 2000) to make way for an alternative 'disturbed 'version. Rather both versions *could exist together at the same time* for consideration by participants of their usefulness in therapeutic work with Indigenous families.

I seek to create a deconstructive account of this research project in my analysis, where meanings I offered could, as Derrida suggests, settle:

> into the distance between what the author consciously intends or means to say (*vouloir-dire*), that is, what she "commands" in her text, and what she does not say and so "sur-prises", overtakes, the author herself. That distance, or gap, is something the deconstructive reading must "*produce*" (Derrida cited in Caputo, 1997, p. 78).

Other examples of how I utilise practices of deconstruction within this project and my analysis include the development of my own researcher questions. I question how issues of power were being played out in practices with participants, and further how I might unsettle the usual researcher-participant power relationship by "experiencing the impossible" (Caputo, 1997, p. 32) to develop more socially just research relationships with participants. I also employ strategies both from the work of Foucault, as outlined in above, and Derrida's practice of deconstruction within my analysis of participants' stories detailed further in my result chapters five to nine. This allowed for an exploration of wider socio-political and historical contexts which were significantly impacting upon participants' therapeutic practices as rural family therapists.

3.5.5 Deleuzian influences upon my analysis

Reading the works of Deleuze initially through poststructural feminists (Davies & Gannon, 2009; St. Pierre, 2001) informs my analysis of this project, in relation to both participants' stories and my own within a process of transformation and change. Within Chapter Seven I utilise Deleuze's concept of "becoming" (Davies & Gannon, 2009, p. 70) to analyse one particpant's story of resistance (Foucault, 1980) to dominant medical practices, as she changed during family therapy training. I also construct my own researcher story of transformation, catalysed by undertaking this research study outlined in my discussion Chapter Eleven. While I predominanatly used these Deleuzian concepts in these two chapters, the theoretical implications of these concepts reverberated throughout my analysis. My own understandings of Deleuze's "theory of becoming" (Durie, 2009, p. 133) allowed me to conceptualise differences between myself and others, problems and their solutions and ways

forward in addressing these, not only within this project but also my own family therapy practices. Deleuze's theoretical concepts of change, transformation and 'becoming', came to sit alongside my other chosen concepts from French philosophers Foucault and Derrida as deeply meaningful for me personally and professionally. These concepts created for me earth-shattering openings into new ways of understanding and pursuing an ethical life McWhorter (2004, pp. 146-159).

3.6 Chapter Summary

Chosen theoretical concepts, such as social constructionism (Gergen & Gergen, 2008a; 2008b), feminisms (Davies & Gannon, 2009; Hesse-Biber & Piatelli, 2007; Oelsen, 2003; Reid & Frisby, 2008), a participatory action research strategy (Herr & Anderson, 2005; Reason & Bradbury, 2008), and influences from French Philosophers Foucault (1980), Derrida (Derrida,1982; Hepburn, 1999) and Deleuze (Deleuze, 1982; Davies & Gannon, 2009; St. Pierre, 2001) have been presented which are influential in my construction of research processes with participants. I have discussed my own positioning as a feminist in relation to this research project, as part of a poststructural feminist move to "think differently" (Gannon & Davies, 2007) as a researcher.

In addition, I have attempted to be reflexive about my own subjectivity (Richardson, 2007) within this research and the impact it has on the structuring of this account. I sought to be transparent about theoretical influences which previously shaped my life as a feminist practitioner and therapist. These influences were carried forward with me into this project as I took up a researcher role. They have therefore also influenced research processes, including data generation and analysis, with my participants. I have acknowledged these theoretical influences here as part of a feminist ethics of transparency (Oelsen, 2003) and reflexivity (Olesen, 2005; Reid & Frisby, 2008), in order to be accountable for my choice and use of theories and their impact within this project. This move is in line with feminist and social constructionist theories, which call for multiple realties and diverse understandings to be valued (Gergen & Gergen, 2008b; Olesen, 2005; Reid et al., 2006) which underpin this study.

Chapter Four

Constructing research processes and practices with my participants

4.1 Introduction

The practicalities of how this study was implemented are presented in this chapter. This includes my reflexive (Reid and Frisby, 2008) account of creating an analysis and use of selected theoretical concepts while doing so.

Firstly I present **My own researcher processes and practices**, which detail how I made contact with participants, following ethical approval, and developed professional research relationships with them as part of a PAR strategy.

Secondly, I discuss in chronological order, the **Practical research processes with participants** which were created to facilitate the co-construction of our stories of rural family therapy practice experiences. This also included planning our analysis together during initial and formal research meetings.

Thirdly I discuss **Creating my analysis** which describes how I developed a layered approach to analysis, and my reflections on a number of dilemmas I faced in doing so. To resolve these dilemmas I return to my use of a dinner party metaphor (Kamler and Thomson, 2006) introduced in Chapter Three, during my analysis discussions. Further invited guests from narrative analysis (Riessman, 2008), social constructionism (Hoffman, 1990), feminisms (Reinharz, 1992; Vickers, 2002; Reid and Frisby (2008), and French philosophers (Foucault, 1980; Derrida, 1982; Deleuze 1988), join me in imagined conversations of selected theoretical concepts useful for my analysis.

4.2 Beginning my own researcher processes and practices

Prior to the research processes with participants, detailed in subsequent sections below, I undertook a number of other research practices and processes influenced

by social constructionist and feminist theories and a PAR strategy. I discussed these research processes with my then PhD supervisors, Dr Elmarie Kotzé and Dr Kathie Crocket and received ethical approval from the ethics committee of Waikato University, New Zealand (Appendix A) to undertake these activities as part of a PAR consultation process .These processes included:

- Initial consultations with rural family therapy practitioners to shape the development of this project
- The development of a series of researcher questions to guide me in aligning with the feminist and social constructionist theories which underpin this project
- Pre-research meetings or discussions with participants to collaboratively construct a research process together and to focus on cultivating relational ethics required for this research project
- The development of an ethical framework for the Gippsland focus group participants.

I commenced these research activities in preparation for the generation of data with participants which followed. I detail these activities below.

4.3 Initial consultation with rural family therapy practitioners

Participants for this research project were sought among family therapists working in rural regions and contexts in Australia who describe themselves as rural family therapists. Given the diversity in family therapy training, it was expected that participants would have a wide range of therapy practice styles and skills.

In considering who my participants might be for this project, I consulted with rural and metropolitan family therapy colleagues and the then co-editor of the *Australian and New Zealand Journal of Family Therapy* (ANZJFT), Maureen Cargo (personal communication, 27 June, 2007). Crago has written on rural family therapy and also has a wide knowledge of family therapy and therapists in Australia and New Zealand. She identified that future research in this area could focus on the strengths of rural communities and their importance for therapists' professional support, sustaining their rural practice. I reflected on her thoughts in the development of the research questions.

I consulted the then Victorian Association of Family Therapists (VAFT). VAFT, formed in 1979, was the former professional association for family therapists in Victoria, and the largest state association for family therapists in Australia (VAFT, 2008), before a national organization called the Australian Association of Family Therapists (AAFT) was formed in 2011. AAFT currently manages professional issues such as membership, ethical concerns, professional development and training (AAFT, 2011b). I spoke with the then VAFT executive officer about what was known at the time about rural family therapists' practice in Victoria. From consulting Maureen Crago and VAFT discovered the following information about rural family therapists in Victoria:

1. A travelling family therapist, Jacqueline (pseudonym), had been teaching family therapy in the rural region bordering the states of New South Wales and Victoria for the past 17 years. The Albury-Wodonga based Border Family Therapy Interest Group (BFTIG) she had been involved with was still in existence when I initially spoke with her (Jacqueline, personal communication, 14 August, 2007), but it has since been disestablished.
2. Four Victorian individual family therapists were spoken of often as having extensive knowledge and understanding of rural family therapy as they had been involved in teaching therapy for at least the last decade.
3. Rural family therapists were forming new professional groups through informal meetings in Gippsland, my region of practice.

I considered that these naturalistic groups and identified individual family therapists would be a rich source of data and stories. I initially chose the BFTIG and Gippsland group of three people as the sites for two focus groups. I also invited individuals identified during my consultation with colleagues to participate in my research project. My choice to invite the Gippsland group and the Albury-Wodonga (BFTIG) group, plus individual family therapists, to be involved in my research allowed for the inclusion of participants who had extensive knowledge and experience with my research topic from two rural regions and two states of Australia (Victoria and New South Wales). These groups of family therapists were already formed, which facilitated my access to them. The main obstacle I foresaw was the large geographical distances between the groups. I considered that this obstacle was

actually an opportunity to explore the issue of distance in rural family therapy often mentioned in literature (Crago & Crago, 2002; Hart, 1986; Weigel & Baker, 2002), and could be part of the research project itself. Individual participants were all located in Victoria.

In the first stage of recruiting participants, I informally approached the two contact persons for the family therapy interest groups in Albury-Wodonga and the Gippsland by email and phone calls. I outlined my research study and asked if they would be interested in considering participating in this. This was part of my initial consultation processes within a PAR study, with ethical approval for this as cited above. I was professionally known to some of my colleagues in the Gippsland region but not to those in the Albury-Wodonga region. I also used the same informal methods to contact the six identified experienced family therapy individuals. I was professionally known to three of these individuals and unknown to the others. I maintained an ongoing collaborative professional relationship with these groups and individuals during this research project.

Members of the two groups suggested that meeting other participants in their region would be useful. I developed timelines with them for an initial meeting, which I called a pre research meeting as part of the steps of the research process for participants, outlined in subsequent sections below. I travelled to Gippsland and Albury-Wodonga for these meetings. However, the BFTIG in Albury-Wodonga disestablished just prior to my arrival and was therefore unable to participate in this research project. Fortunately the contact person for BFTIG agreed to an individual interview and was involved in this study. After obtaining ethical approval from the Waikato University ethics committee I sought out another established group of rural family therapists in Tasmania, from a further contact person known to me, after seeking approval for this project from the to do so, as cited above A group of five participants from Tasmania agreed to a small group interview rather than a focus group, due to the limited time available for this project.

Beyond these two groups, there were six identified individuals whom I invited into the project. These identified individuals, including the BFTIG contact person, informally indicated their interest in participating in individual interviews after my initial

approaches to them by phone and email. The BFTIG participant and I negotiated undertaking a phone interview together at this time due to geographical distances involved. The other five individual interviews were seen as a more practical way of meeting each participant, rather than attempting to get all the individual participants together in a focus group, given again, the large geographical distances and their limited time availability. My intention in undertaking an ongoing consultation with participants was to consult and include them in the development of the research project as fully as possible given the constraints noted above.

I discussed with all participants individually my idea of talking together about rural family therapy, as part of a PAR study so that more could become known of our practice and experiences. While I initially chose this broad research topic, it was my intention that participants themselves would identify the details of how and what would be discussed, in line with a PAR strategy (Reason & Bradbury, 2008).

4.4 My own researcher questions

To guide myself in addressing the research question and objectives with participants I developed a set of my own researcher questions, in consultation with my original PhD supervisors. I distinguished between these questions at three levels: Meta, process and content. These research questions were temporary ones which guided me in shaping the initial research meetings with participants from which further research questions were generated. The openness of the research questions was to allow for a collaborative construction of further research questions with participants, informed by a participatory action research (PAR) strategy, which values collective learning by participants (Kemmis & McTaggart, 2005, pp. 566-68). In this:

- Meta questions guided me in using PAR at a research practice level
- Process questions around PAR enabled me to engage with participants as a researcher in this project
- Potential content questions were those that the research project proposed to investigate.

My own questions to guide myself as feminist researcher within this project were:

1. (*Meta question*) What does participatory action research contribute to sustaining and/or developing the practices of rural family therapists?

2. *(Meta question)* How do feminist and social constructionist knowledge's contribute to the development of this project as participatory action research?
3. (*Process question*) How do I engage communities of family therapy colleagues in a participatory action research process that will be relevant and meaningful to our practice in rural contexts?
4. (*Process question*) On the basis of this engagement, how do communities of family therapy colleagues use participatory action research to co-construct a process that will be relevant and meaningful to our practice in rural contexts?
5. (*Content question*) What research questions are relevant and meaningful to family therapists in these rural communities of practice?

The tasks involved in responding to these questions included:

1. Collaboratively negotiating and setting an agenda for the focus of the research inquiry with participants
2. Collaboratively negotiating and agreeing to the overall process and orientation of the research
3. Collaboratively negotiating and agreeing to the data generating processes to be employed
4. Collaboratively exploring, negotiating and agreeing to the data analysis processes to be employed
5. Collaboratively exploring, negotiating and agreeing to the process of dissemination of knowledge generated
6. Negotiating and clarifying with the groups and individuals (a) the aspects of the project that are my PhD and therefore my responsibility to complete, such as a written account of this study and (b) what aspects of this research study might be useful to participants within their own practices. The Gippsland focus group identified that having a regular series of focus group meetings to discuss rural family therapy together was useful to them. They would not have met to talk about this topic otherwise. I discuss this aspect of this study further in my final discussion chapter.

Each of these tasks involved a complex negotiating of relationships of power (Reid & Frisby, 2008). As an insider researcher my hope was to exercise leadership in ways that acknowledged these power relations.

4.5 Pre-research meetings

I used PAR in initial research meetings with focus group participants to collaboratively construct a research process as part of a PAR entry process (Herr & Anderson, 2005, p. 92). For individual, small group and the one phone interview I used these PAR principles in a discussion with participants prior to commencing the interviews. This collaborative research process guided us in developing how we might work together within this project and the next stages of the research. I worked with participants to cultivate the relational ethics (Ellis, 2007) required for this research project, clarifying issues such as potential ethical dilemmas we might face and how we might develop ways of addressing these potential issues together. An example of this was the ethical framework developed with the Gippsland focus group together, detailed in subsequent sections below. These were the steps I took towards reflexivity, making overt the power and boundary issues within this project which needed to be addressed in order to minimise the potential for misunderstandings and to establish clear roles within the project (Etherington, 2007, pp. 602-606).

I also drew upon the work of the Public Conversation Project (PCP) of Herzig and Chasin (2006) to guide me in facilitating dialogue with participants of differing theoretical orientations. The PCP has developed a guide to facilitate the bringing together of people with opposing views, such as those involved in the conflicts of war or debates around religious and sexuality differences, to enable dialogue that develops “more respectful and effective ways of relating, [thereby facilitating] greater mutual understanding, and deepening trust” (Herzig & Chasin, 2006, p. i).

I asked questions, such as the examples which follow, in the focus group, small group and individual interviews to facilitate participants viewing the research from a contextualised position. The work of family therapists Herzig and Chasin (2006) was a source of information and inspiration to me in developing questions with participants as the research unfolded. I valued the work of these therapists, which allowed me to encourage dialogue across any differences we had as rural family

therapists. I believe Herzig and Chasin's (2006) theoretical approach was of value both to participants and myself as we initially engaged in this research project.

While the research questions which follow were offered to all participants, it was the Gippsland focus group who embraced the use of these to develop an ethical framework for working together which was used within this group's research meetings. These questions also fostered conversations around differences in understanding issues of intersectionality which form the basis of Chapter Eight. This framework was crucial in later giving participants permission to speak of intersectionality issues they were attempting to transverse within their therapy practices. The stories Gippsland participants offered in this study have relevance to other therapists in providing new understandings of working across issues of class, race, culture and gender.

Questions related to ethical considerations of diversity and difference were as below. I present these questions here in their original form, as initially approved by the Waikato University ethics committee I distinguished between these questions of ethical considerations of diversity and difference using the same three levels as for my own researcher questions: Meta, process and content.

I understood these as such:

- Meta questions guided me in developing ethical approaches to diversities and differences within this project at a research practice level
- Process questions were designed to engage with participants in this project
- Content questions were those which participants addressed as part of the collaborative development of an ethical framework for this project, developed in initial pre-research meetings together.

1. (Meta question) How do participants understand and respond to diversities and differences of gender, ethnicity and culture that demonstrates respectful and just power relationships?
2. (Meta question) How do participants understand and respond to diversities and differences of family therapy theory and practice with each other that demonstrates respectful and just power relationships?

3. (*Meta question*) How do participants understand and respond to any other differences and diversities generated by the research questions and processes of this research project that demonstrates respectful and just power relationships?
4. (*Process question for myself as the researcher*) How do I as an insider researcher to this project facilitate the valuing of differences and diversities generated by the research questions, processes and participants?
5. (Content question for participants) What are the differences of culture and gender we bring to this research and how do we respond to these differences in ways that are respectful and just?
6. (Content question for participants) What are the differences in family therapy theory we bring and how do we respond to these differences in ways that are respectful and just?
7. (*Content question for participants*) What are the differences in family therapy practice we bring and how do we respond to these differences in ways that are respectful and just?
8. (*Content question for participants*) Are there other differences we bring that I as the researcher have not known to ask about? If yes, how do we collaboratively negotiate ways to work with these differences together that are respectful and just?

4.6 Practical research processes with participants

I now introduce my participants to readers. Following this I present in chronological order, the research processes developed with participants from my initial ethical approval for this study from the ethics committee of Waikato University, New Zealand (Appendix A), through to the completion of research meetings with participants

I begin my introduction of participants by acknowledging the extent of their expertise. Many of them are well known and respected in the field of family therapy, having contributed significantly in senior positions to professional bodies associated with family therapy and counselling over the last two decades. Their practice knowledge and wisdom is extensive and graciously shared with students and colleagues while practicing and teaching within rural contexts. I have personally witnessed and been

involved in their therapeutic and teaching practices over the last decade and feel privileged to have done so. This knowledge and wisdom was also reflected within the depth and complexity of the narratives of rurality co-constructed between these family therapists myself. These participants are frequently recognised as leaders in their field because of the unassuming, yet superbly sophisticated approaches they bring to their family therapy practices.

Study participants included three distinctive groups from (a) Gippsland, (b) Tasmania and (c) Individuals from Victoria, comprising a total of 14 participants. The following names of participants are pseudonyms, chosen by them during our research meetings together. The three Gippsland participants, Anna, Daisy and James agreed to form an ongoing focus group that met over a twelve month period on five occasions, while the five Tasmanian participants, Alana, Angel, Audrey**,** Kitty and Julia agreed to one small group interview in Tasmania. The remaining six participants Dorothy, Eleni, Jacqueline, Mark, Roxy and Sigmund each agreed to have one individual interview within the region of Victoria. All of these participants identified themselves as rural family therapists and were involved in therapeutic work related to these roles.

Research meetings were of a one to one and a half hour time duration for all participants involved, on each occasion. These times were part of a mutually agreed plan, developed between myself and participants, within our initial meeting discussions together as part of a PAR strategy. However, there were also informal conversations between myself and participants before and after research meetings. Frequently these conversations included asking how each other was doing within our professional practices and general lives. Often participants and I asked each other about our various family members' known to us, and their general wellbeing. These conversations were not recorded although I consider them an important part of the development of my research with relationships with participants, and consistent with feminist research principles (Reinharz, 1992).

Participants' practice experiences ranged from four years practice to over twenty years as family therapists. The professional backgrounds of my participants' included: psychology, psychiatric nursing, social welfare and social work. One

individual participant, and all of my Gippsland and Tasmanian participants were working in social service and health organisations as family therapists. Five of my six individual interviews were with participants working in private practice settings. I have not outlined any further specific details of my participants' locations or practice settings, in consideration of their confidentiality and anonymity within this study. Rural communities are often small and family therapists working and visiting within these settings are often known to many within these locations. To protect my participants' identities the only details of their practices and locations are broad and non-specific, as above.

Approval for ethics and my final research plan was given by the ethics committee of Waikato University, New Zealand (Appendix A). I followed up on any informal interest from participants to take part in the research project. Subsequent to this, and after data generation and analysis were well advanced, I transferred this PhD project to Monash University, Australia (Appendix K). Ethics approval for this project was granted by Monash University at this time of transfer (Appendix L). Following ethics approval I sent participants:

A formal letter inviting them to join the research project (Appendix B, Appendix C, Appendix D).

a) Further information for potential participants explaining the project's aims, plus an outline of potential research processes (Appendix E).
b) A withdrawal from research form (Appendix F)
c) Informed consent forms for focus group or individual interviews (Appendix G, Appendix 8, and Appendix H).

I allowed 2-4 weeks for the return of informed consent forms by mail to me in reply paid envelopes. This enabled participants to make their decision independently of my physical presence, which may have been perceived as coercive. Participants were also asked to identify their preferred method of future communication at this time, which I adhered to in future communications with them.

Four weeks after sending the invitation to participants, I acknowledged in writing all returned informed consent forms I received. I then contacted those participants who had returned their informed consent forms in order to schedule the pre-research

meetings for the Gippsland focus group and Tasmanian small group, and the individual interviews, as detailed in following sections of this chapter.

4.7 Steps in the research processes

Fourteen participants in total were involved in the following research steps:

Step 1. I met with all participants in an initial meeting, which I called a pre-research meeting, to discuss how we might generate data together around my research topic. During this meeting I asked participants which, if any, of my research questions outlined in Chapter Two, were relevant to them and if they wished to discuss any of these during our formal research meetings. I asked them to consider what aspects of their rural family therapy practices and experiences were important to them to also be discussed at this time. Allowing participants to choose their own research questions is supported by PAR and feminist research principles (Reason & Bradbury, 2008; Reinharz, 1992). All participants identified that they wished to talk together around topics chosen by them, and that my research questions served as a prompt, which they reviewed when these were initially sent to them.

Participants were asked to nominate what format our formal research meetings together might take that would be most useful and practical for them. The Gippsland participants chose a focus group format to generate data together, while the Tasmanian group chose a small group interview format. The remaining six participants chose to each be involved in an individual interview with me. I met with five individual participants in person for their individual interview and conducted one interview by phone at this participant's request to do so, due to the geographical distances involved. I allowed time in this pre-research meeting to answer any questions regarding the information I had previously sent them. This information included an outline of this study, its aims and an introduction to them of myself as a practitioner researcher and what I hoped to achieve in undertaking this study (Appendix E). This self-disclosure about myself as a practitioner researcher, was part of being transparent about my values, beliefs, intentions and motives for this research project so that these could be made available for my participants to critique, as an important part of feminist research (Etherington, 2007; Reinharz, 1992). I also believed this self-disclosure and discussion contributed to the development of trust

between myself and the participants, a vital part of the research relationships (Reinharz, 1992). In establishing this trust within the research relationship I hoped that participants would become comfortable with the research process and therefore able to focus on how we might work together in ways that were meaningful for them. I believe this hope was achieved by my participants agreeing to be part of this study, and by the richness of the data generated with them.

Step 2. Formal research meetings occurred with all participants, in the format outlined in step one above, including their choice of topic to be discussed. I asked participants to have a conversation with me about aspects of rural family therapy which were important to them. All participants had their experiences and stories audio and video recorded. This occurred in a total of five focus group meetings for the Gippsland participants, in one small group interview for the Tasmanian participants and in one individual interview for all other participants. For participants, the experience of being filmed was a common practice for them as family therapists seeking to improve their practice or as part of their initial training. It was therefore a familiar practice for participants to be filmed during conversations.

Step 3. I personally transcribed a written transcript and created a DVD of the audio and video recordings from each meeting which was given to all participants from the sessions they participated in. I returned these transcripts and DVDs to participants within one week of their meeting. Participants were asked to read their transcript or view their DVD for two purposes. Firstly to check that I had accurately recorded what they had said and to allow them to correct anything they wished changed in their transcript or DVD. Secondly participants were asked to reflect on their transcript or DVD as detailed in step three below.

Step 4. Participants were asked to review, reflect upon and give any feedback they wished to from the written transcripts and DVD's they had been given. For the Tasmanian group and individual participants I made contact by phone and email to ask for this feedback, given the geographical distances involved. This had been agreed to in our initial discussions. For the Gippsland focus group I asked them for feedback at the beginning of our subsequent focus group meeting. My own notes and ideas, taken from the recorded session, were introduced for review by

participants only after my participants' own ideas had been discussed first. While I was a fellow participant within this research study, I prioritised participants' feedback over my own in line with a PAR strategy (Reason & Bradbury, 2008).

I also asked participants during their feedback if they have noticed any changes in themselves or their practice as a result of their participation in this research project. This question was informed by the work of narrative therapist Gaddis (2004) who suggests this type of question is a useful process within research. Part of my intention in doing this project was to explore with participants the meanings of any impacts from this research upon their future practices. This question also allowed for a meta-perspective on the research project itself. This meta-perspective opened space for me and the participants to deconstruct what our practices and experiences of rural family therapy were, as well as how we had co-constructed our views of rural practice and ourselves within this research project.

Final step. There is a final and yet uncompleted step in my research process with participants. That is, the return of a copy of the finalised written account of this study to all participants, as negotiated with them in our initial pre research meetings. This is to be completed when this study has been completed. This is in line with a PAR strategy and an important part of feminist research, in giving back information and research findings to participants involved (Reason & Bradbury, 2008; Reinharz, 1992).

4.8 Collaborative data analysis

My initial research plan outlined my intentions of collaboratively analysing data together with participants. as it was generated, as part of a PAR strategy. PAR is an emergent process (Reason, 2006) with expectations that there will be shifts in research design, methodology and processes as data is gathered (Herr & Anderson, 2005). These shifts form part of PAR cycles of planning, action and reflection with participants and they guide the research process (Herr & Anderson, 2005; Reason & Bradbury, 2008). This approach was to allow for me as a researcher to adapt to participants' perspectives and the research being generated (Herr & Anderson, 2005; Morrow, 2007). I offered participants a range of tools to develop their own preferred approaches to analysis. Examples of approaches to analysis offered to

participants included, Foucault's work on power and knowledge (Foucault, 1980; Sedgwick, 2001) and Narrative therapy (White & Epston, 1990; White, 2007). I did remain open to suggestions from the participants themselves on approaches to analysis on the basis of their own research experiences. However, as the researcher, I carried the responsibility for the strategy selections that were made.

Despite my planning and discussions with participants to undertake a collaborative analysis together, they were not able to do so. Participants reported that they were able to give feedback in research in steps 1-4 as outlined above, but were not able to be involved in further analysis due to their busy work schedules as practitioners. My participants' interest and time available for this study was limited to the actual research meetings together. Many of them worked in private practice and time not working meant a decrease in their income. For other participants employed within social welfare and health organisations, their workloads were significant. This workload necessitated them prioritising their therapeutic work with families over this research study. I respected participants' choices as part of a PAR strategy, which focuses on participants' perspectives to drive the process (Herr & Anderson, 2005; Reason & Bradbury, 2008). I also understood and identified with my practitioners' focus on therapeutic work and income generation myself, as a part time private family therapist.

4.9 Creating my analysis

As I reflected on how I was to move from completing my data generation with participants into my analysis, I was faced with a number of dilemmas. Firstly, I was not able to undertake a collaborative analysis process as part of a PAR strategy with participants as I had initially planned. This was related to their feedback on their unavailability, as discussed above. My analysis was to be a narrative one, utilising the work of Riessman (2008). My choice of a narrative approach to my analysis fits with my participants' skills and experiences as family therapists. Understanding the meaning of clients' stories is a significant part of therapy, and a familiar way of working for them. I had anticipated participants and I constructing narratives together with them as active participants. I now found myself in a position of having to develop an independent narrative analysis which respecting participants' requests to

not be involved in this ongoing process. I was also required to develop an analysis which was inclusive and respectful of participants' contributions in their absence, aligned with feminist and social constructionist theoretical positions chosen for this study.

Secondly I was faced with an enormous amount of research materials and data to be analysed. Participants' stories were required to be analysed holistically, rather than in fragmented sections, with attention to the contexts and histories of these stories, in line with a narrative approach (Riessman, 2008). Data included: my written transcripts from research meetings with participants; DVD's and visual materials of these same interviews in a DVD format; and written reflections and comments from both participants and myself from our research meetings together.

Many of my participants' stories included examples of power and their resistance (Foucault, 1980) against dominant understandings of their rural practices. My final dilemma was how to more finely analyse participants' stories to reflect these complexities, while not claiming a position of privilege as researcher over my participants while doing so.

To address these dilemmas I began by reflecting on the work of Riessman (2008), which I had previously chosen to guide me during my analysis, in both a theoretical and practical sense. Riessman's (2008) interpretive work focused my attention on not only participants' stories, but also the context within which these stories were being told. The context of rurality was significant to my participants' experiences of practice, as well as being part of the focus of this study.

I then reflected on my own conceptual understandings of social constructionist and feminist research principles, alongside chosen concepts from French philosophers Foucault, Derrida and Deleuze introduced to me by poststructural feminists cited previously in Chapter Three. From these reflections I identified important theoretical concepts which I included in the development of a layered approach to my analysis which I discuss in the following sections. My development of this analysis, which included practices of deconstruction, allowed for 'disturbed' and 'undisturbed' versions of participants' stories to be able to sit alongside each other in a Derridean

sense (Derrida, 1982). My understandings and a deeper analysis of issues of power and resistance within my participants' stories was facilitated by this approach. In my discussions below I re-introduce Kamler and Thomson's (2006) concept of using of a dinner party metaphor to extend my conversations with newly invited guests. The purpose of these conversations was to further inform the development of my analysis by deliberating on chosen theoretical concepts together

On this occasion my guests from narrative analysis, social constructionism, feminisms and French philosophers Foucault, Derrida and Deleuze joined me to discuss my analysis together, outlined below. While each of these theorists was important in the development of my analysis, it was the work of Riessman (2008) which was the most significant in the shaping of my final approach to analysis. Therefore Catherine Riessman was the most important guest to me within this part of my dinner party conversations. I have adopted Riessman's practice of understanding the term story and narrative as synonymous, and use both of these terms throughout this study. I introduce my own understandings of Riessman's (2008) work which I utilised within my analysis. Following this I introduce other of my guests, who later joined Catherine and I, to discuss aspects of their work I also found useful during analysis.

4.10 Narrative analysis

Riessman (2008) describes narrative analysis as trying to understanding the stories participants tell during their research interviews. She suggests, "Narrative analysts interrogate intention and language-*how* and *why* incidents are storied, not simply the content to which language refers" (italics as in original, p.11). She outlines methods for analysis including (a) Thematic analysis which focuses on the content of the data, creating themes from an overall narrative; (b) Structural analysis which analyses not only the content of a narrative but how it is organised or structured; (c) Dialogic/performance analysis, which analyses how researchers and participants converse together to create and perform narratives and (d) Visual analysis which analyses visual materials such as film, video and photographs. Influenced by Riessman (2008), I utilised aspects of each of these methods within a layered

approach to my analysis of this study's data. I present each layer of my analysis, and my purpose in undertaking this approach in the following sections below.

I began with my initial analysis of stories told by all of participants, which created overall themes I utilised to develop my results chapters. Following this I chose sections of participants' stories, from these overall themes, to be included in my results chapters. These, and my discussions of them, became the contents of my results chapters. These analytic methods allowed me to not only make sense of participants' stories but also the context also within which they told these stories. That is, the context of rurality upon family therapists' experiences and practices, the focus of this study.

Riessman (2008, p. 137-139) proposes that a narrative dialogic/performance approach to analysis:

> draws upon components of [narrative] thematic and structural analysis, but folds them into broad interpretive research inquiries. Attention expands from detailed attention to a narrator's speech … to the dialogic environment in all its complexity … Attention to broader contexts, beyond the interview or ethnographic situation, is a great strength of the dialogic approach.

Riessman's dialogic/performance approach guiding me during my analysis to consider the wider socio-political and historical contexts within which participants' stories were embedded. I repeatedly reviewed written transcripts and DVDs of participants' stories as Riessman (2008, p. 108) suggests, seeking to read or view them "differently" each time. For example, in one reading or viewing I would search for my own range of interpretations of participants' use of language and expressions from written transcripts. In another separate viewing I would search for participants' emotionality in connection to stories they were telling within their DVD recordings. In this approach to analysis, "context gets considerable analytical attention" (Riessman, 2008, p. 116), allowing me to understand both individual participants' stories, as well as links to the wider contexts in which these stories were located.

Another aspect of Riessman's dialogic/performance analysis important to my own analysis was her use of a multiple and layered approach. Riessman (2008) outlines

her initial use of narrative thematic analysis, followed by a dialogic/performance analysis in her text. Her purpose in this approach is to locate her participants' stories not only within wider contexts but to also involve herself *as an active participant within her own analysis processes.* Riessman (2008, p. 116) describes this approach to her analysis:

> I used thematic materials from earlier parts of the interview, and located the [participant's] personal narrative in broader historical and economic contexts … I also included myself as an active participant in the narrative and its interpretation – a distinguishing feature of [narrative] dialogic/performance analysis.

This aspect of active researcher involvement within dialogic/performance analysis sets it apart from other narrative approaches to analysis. It was also important to me for the opportunities it gave me as an author to include my own active involvement as a participant within this written account. Riessman (2008, p.139) comments, "…meaning in the dialogic approach does not reside in the speaker's narrative, but in the dialogue between speaker and listener(s), investigator and transcript, and text and reader". An example of my active involvement within this study was in my inclusion of sections of my own conversations with participants during our research meetings within my results chapters. Riessman (2008, p. 137) proposes that this opportunity for active involvement is also available to readers, noting that within dialogic/performance analysis:

> intersubjectivity and reflexivity come to the fore as there is a dialogue between researcher and researched … The research report becomes 'a story' with readers the audience, shaping meaning by their interpretations.

While I sought to engage all of my participants in a collaborative approach to generating data together, many chose to perform their narratives in other ways. Participants within individual interviews created and performed their stories as an interview process, rather than as the dialogical research conversations I had anticipated. Individual participants cast themselves in the role of an interviewee, with myself as their interviewer. I began the interviews by reminding participants of potential research questions to be discussed (outlined in research steps 1-4 above). I did however, allow participants to choose what aspects of their rural family therapy

practice experiences they wished to discuss, as part of a PAR strategy. This also in line with a narrative analysis approach. Researchers facilitate their participants to tell stories during data generation because, "... if narratives of experience are desired, storytelling must be allowed" (Riessman, 2008, p.23). Individual interviews were not as dialogical as I had planned for. However, I respected my individual participants chosen roles as interviewees as part of a feminist influenced PAR process, which calls for participants' choices to be prioritised (Reason & Bradbury, 2008).

My involvement with my Tasmanian participants did however include aspects of my own dialogical conversations with them, as part of their one small group interview. Transcripts from this interview reflect this as in the example below:

> Annette: (to all of the group) *um well, what was in my head as I was listening to you, I'm thinking, I'm getting more and more depressed over here* (listening to groups comments about struggles of working rurally). *Underpaid, stretched resources. You are sounding like us* (rural Victorian family therapist). *Like um, why are you still here. Like, why is it you are still working here?*
>
> Julia: *Can I answer that? Can I? Can I?* (Said very enthusiastically and with humor-laughs as she says this).
>
> (Group also laughs together).
>
> Annette: *Well, you sitting next to the teacher* (referring to another Tasmanian group participant). *She can give you permission* (said humorously).
>
> Julia: *I just think I'm really fortunate where I am working currently in a small rural community with lots of outlying little hubs if you like. And um I think actually that the family therapy part of my work just pulls that together beautifully. You know, that opportunity to maximize the resources that we have. To build really strong relationships, you know, the school, the community house and with myself. That's about us really* (laughs). *But that's good*.

This example highlights the dialogical aspects of our group interview together. Our conversations together created both the direction and content of what was discussed, as it was occurring. This is significant because without me asking Julia the question of why she remained working in a rural context, despite numerous

challenges, she might not have otherwise discussed this topic. Julia's response to this question was important to her and expressed in her enthusiastic response. The group recognised this enthusiasm and responded by all laughing together. My asking of this question was part of my specific intent to explore issues of sustainability for rural family therapist, during our conversations together. This had been previously discussed in initial research meetings with all participants and agreed to as part of setting up the research processes, outlined previously.

My research conversations with the Gippsland Focus group were the most active of all participants. Again, this is reflected in my transcripts from these meetings. I have included my own conversations within stories from the Gippsland focus group participants, as part of my results Chapter Eight.

My level of my involvement as a fellow participant during research conversations with participants, is reflected in my results chapters. As such Chapters Five, Seven and Ten reflect my participants chosen roles as interviewees and my own corresponding role as their interviewer. As previously discussed, my role in these research conversations is limited to that of an interviewer and does not include myself as a dialogical participant at this time.

The remaining results chapters, include research conversations with my Tasmanian participants, as part of their small group interview, and my Gippsland participants as part of their ongoing focus group. Both of these chapters reflect my greater involvement as a fellow participant within these dialogical conversations together. The Gippsland focus group met over the longest period of time of twelve months, of all my participants. It is likely that given this length of time my relationship with them as a researcher allowed for a level of trust to develop, facilitating my role in their conversations. This fits with Reinharz's (1992) original work on the importance of research relationship with participants, within feminist research projects.

4.11 Visual analysis

I observed during my research meetings with participants times where they expressed themselves with more emotion or emphasised certain words or phrases,

while telling their stories. I noted in my researcher diary at the time that Dorothy's story seemed important and her words "*gossamer threads*" were beautiful. In addition that I needed to pay more attention to this story during my transcription to understand the meaning of this story to Dorothy.

These stories from participants were significant to me as both a researcher and family therapist. Family therapy training had sensitised me as a therapist to recognising important moments within therapy for clients, linked to their emotionality and use of language. As a researcher I was drawn to these same moments, from my previous reading of Riessman's (2008) work on expressive language. She calls researchers' attention, during analysis to participants' language as they "*dramatize*" their stories (Riessman, 2008, p. 112) (Italics as in original). For example, participants may repeat important moments of their stories, or speak as an aside to the researcher, or speak in both past and present tenses at the same time (Riessman 2008). Attention to these narrative techniques engages researchers in participants' stories, while also allowing participants "agency... [as] the narrator" (Riessman 2008, p. 113).

I discovered that certain words, expressions, tones and sounds uttered by participants during conversations came at moments important to them; often expressed emotionally. Riessman (2008, p. 113) understands these materials as "*expressive sounds*" used to engage listeners (italics as in original). For Riessman (2008, p. 109) this style of analysis allows her as researcher to experience, "unfolding events *with him* [her participant], reliving the events and identifying with him ... [in a story that] ... bleeds the pain of disability in social space" (italics as in original).

In line with an understanding of transcription as an important part of understanding participants use of language (Riessman, 2008), I had chosen to transcribe all my own data. During my transcription I developed my own system of symbols to note occasions of participants' use of expressive language, noting when these experiences occurred. This included highlighting sections of transcripts which were emphasised by participants, counting time in seconds where participants were silent or thoughtful following emphasised comments, and including in brackets the context

of what was occurring during these times of expressive language. Below is an example of my transcription from Dorothy's individual interview, in relation to our discussion together of family therapy training and its significant impact on Dorothy's work with helping suicidal young people:

> Dorothy: *This sounds a bit* (Two second pause) *this sounds a bit fanciful but it's actually* <u>*true*</u> (emphasised), *that instead of actually going to peoples' funerals I started going to peoples' weddings.*
> Dorothy*: Um so that the differences in the students is, what are the differences?* (Asking question of herself) (3 second pause) *um* (5 second pause. I saw that Dorothy was thinking deeply here when I reviewed our DVD of this interview) *there's an* <u>*ease*</u> *(emphasised) amongst the students* (Conversation together of differences between rural and metropolitan family therapy students).

I found reviewing visual forms of data such as those in this example allowed me to analyse participants' unspoken moments, pauses, emotions and use of expressive language as part of their verbal and non-verbal communications. Using visual analysis alongside written materials allowed me to gain, as Pink (2007, p. 135) suggests, "…important insights as each medium may represent interrelated but different types of knowledge".

Inspired by the work of Pink (2007) and Riessman (2008) on visual analysis, I analysed my data in both written and visual forms. This included participants' transcripts from research meetings (written form) and participants' DVD's from research meetings (visual form).

Participants' emotions and use of expressive language drew my attention to important moments within our research conversations together during my analysis. These important moments contained stories of significance to participants. In line with a narrative analysis Riessman (2008), I located the beginning, middle and end of these stories from the wider conversations with participants. I then grouped these stories together, initially using narrative thematic analysis (Riessman, 2008) to create overall themes from the whole of the data. These themes became the basis of my

result chapters and include issues of importance to participants, reflected in the titles and contents of my results chapters. This initial thematic analysis, allowed me to offer potential interpretations of participants' experiences in my results chapters, linked to a social justice agenda, chosen and acknowledged by participants and myself in pre-research discussions. I do however acknowledge that my own emotions as a feminist researcher and family therapist were engaged in listening to expressive and emotive elements of participants' stories. I have, nevertheless, sought to privilege participants' voices within the results chapters of this study as part of a feminist influenced PAR research strategy (Reid & Frisby, 2008; Reinharz, 1992; St. Pierre & Pillow, 2000; Reason & Bradbury, 2008; Herr & Anderson, 2005). Overall themes from my initial narrative thematic analysis within my results chapters included:

- Understandings of rurality and rural practices from participants (Chapters Four and Five).
- One family therapist's story of transformation and change (Chapter Six).
- Intersectionality issues (Chapter Seven).
- Multiple relationships in rural communities (Chapter Eight).
- Rural family therapy training (Chapter Nine).

4.12 Post-research processes issues

Following the completion of data generation and the commencement of analysis, I experienced communication difficulties across the distance between myself in Australia and my then PhD supervisors in New Zealand. After conversations with local academic colleagues, I transferred this research project from Waikato University, New Zealand, to Monash University, Australia, in June 2012. I advised participants of these changes by their previously chosen mode of communication, and provided them with the contact details of my new PhD supervisors. I also alerted them to the access these new supervisors would have to the research data we had generated together and informed them of their right to contact these supervisors with any queries related to this.

4.13 Chapter summary

Within this chapter I have outlined the practicalities of the research processes co-constructed with my participants. These included the involvement of fourteen

participants in the generation of data within their choice of an ongoing focus group, a small group interview or an individual interview. I have also outlined how influences from feminisms, PAR and family therapy theories shaped the development of research processes with participants. Examples of this include the development of my own researcher questions to guide myself as feminist researcher within this project, and the development of a theoretical ethical framework with the Gippsland focus group

I have described my layered approach to analysis, informed by the work of Riessman (2008), on narrative thematic, dialogic/performance analysis and visual analysis. Chosen concepts from French philosophers Foucault, Derrida and Deleuze have been introduced for use in my next layer of my analysis, in subsequent results chapters six to ten. I have highlighted my collaborative approach to research generation and analysis, and the post-research issues of the transfer of this PhD project from Waikato University to Monash University following data generation and analysis completion.

Continuing with Kamler and Thomson's (2006) metaphor of hosting a dinner party, I now invite Foucault, Derrida and Deleuze to each join me to discuss my analysis within chosen sections of my results chapters which follow.

Chapter Five

Rurality and rural practices

What is rural, what is rural practice? (Roxy).

5.1 Introduction

Participants' perceptions of rurality are explored in this chapter to discover the different ways being 'rural' impacts on their family therapy practices. The longest and most descriptive narratives of rurality are from individual interviews with Roxy and Sigmund. Elements of their stories are reflected in all my participants' narratives. As such, their stories provide readers with an overall introduction to participants and my own understandings of rurality and rural practice. In addition, these initial understandings form a foundational understanding of rurality which I build upon during my analysis in subsequent chapters. Roxy and Sigmund swiftly took ownership of their conversations, performing their stories as sole narrators while positioning me as their audience. I had anticipated a more dialogical approach (Riessman, 2008) during these interviews. However, consistent with a PAR approach, I respected my participants' choices of how to perform their stories. Therefore, I privilege my participants' style of narration within the following stories, interrupting this process only to guide readers between stories, using my analysis to highlight important concepts as I do so.

All participants' stories also identify with a predominantly metro-centric narrative of the limitations of rurality and rural practices. For example, rurality is understood as a deficiency of resources, geographical distances and rural practices reflected in my literature review. Excerpts from narratives provide readers with a largely 'undisturbed' introduction to participants' everyday rural practices, including examples of the complexities they work with in their rural contexts. This introduction scaffolds my further exploration, discussion and 'disturbance' of these complexities in subsequent results chapters

Of significance during my analysis, was the early emergence of contradictions within participants' opening narratives. Participants' perceived their practices within a

context of rurality as a challenging space, *and at the same time* a relationally important space to live and work within. These contradictions were meaningful fragments of an emerging counter-narrative of understanding rurality as relational.

I typically began my research conversations with participants by asking them what they wished to discuss in relation to their own experiences and practices of rurality. From this invitation many of my participants launched straight into their stories of rurality with minimal encouragement from me. They spoke with passion and warmth towards their clients and families, expressing empathy for the struggles these families bought to therapy.

5.2. Roxy's story

Roxy and I are sitting on individual couches alongside each other, in one of the family therapy rooms we use in our private practice work together. She looks at me expectantly as I finish explaining again the purpose of this research study while setting up the camera to record this conversation. I hand her a written copy of my research questions which we have previously discussed as a prompt to begin.

> Annette: (Referring to research questions handing to Roxy) *It's about practice, what is rural family therapy practice? What do we do? What are our practices, what does it mean to be a rural family therapist? Do you want to talk about those* [Questions]? *Or? What would you like to talk about*? (I have a cold during this interview and sniffle into my tissue here, while apologising for doing so).
>
> Roxy: *Well the first one* [Question] *is hard for me to answer because I don't consider I'm rural* (Looks to Annette in an enquiring way).
>
> Annette: *Ok* (Nodding gently to affirm Roxy's comment and encourage her to continue).
>
> Roxy: *Although I know I am* (Smiles at Annette).
>
> Annette: *That's interesting* (Nods slightly to acknowledge Roxy's comment).

Roxy: *Rural for me is almost outback*.

Annette: *Ok*.

Roxy: I think I'm in a little city here but I think it's harder for family therapist or any counselling…

We are interrupted by a phone ringing and wait while an answer phone deals with this.

Roxy :(Continues her conversation. She pause for three seconds while thinking) *I don't see other family therapists, so there's that. You don't feel maybe as connected as you would in Melbourne.*

Annette: *Makes sense to me. What sort of picture do you get of rural family therapy? Do you get a picture or idea of what rural family therapy is*? (I Look at Roxy while asking this. I have called upon my previous relationship with Roxy as an experienced family therapist to ask these questions. I know she will understand my therapeutic strategy of asking these questions as a visual metaphor, to allow for other ways of understanding rural practice to emerge).

Roxy: *Yeah, well I don't consider this is it* [Referring to her own therapy practice location]. *I consider this is a town because I live here. For me rural family therapy would be like somewhere like Bega* [New South Wales location] *where there is, you know open fields there. But you know where it is*? (Looks at Annette with this question in her eyes).

Annette: *Well, the cheese place*? (Bega known for this).

Roxy: *Yeah there is the cheese* (We laugh together) … *But there is you know, a lot of cows everywhere you look. Like going for a drive and all you see are cows, and having one family therapist there, you know people would come for miles to see*.(Pause for 3 seconds while thinks) *and after saying that*…

Annette: *I was just thinking that* (I Laugh with Roxy. We are acknowledging that we are on the same wavelength here in out laughter and creating these

sentences together. We recognise she has said she isn't rural, then in her description realises, yes she is!)

Roxy: *After that comes out my mouth that is exactly what happens here. We just don't have so many cows around…Although you know to go shopping or go to the next town I have to go past cows in a field. So why would I think that wasn't rural*? … *What is rural, what is rural practice*? [Questions she asks herself. Pauses while thinking). *Well I think rural by definition is when you get a lot of farming people that you have to be with, which we do so we are rural. So what does it mean for your practice*? *Well I guess it means that you get a lot of hard people, people with hard stories, with a lack of money. In this day and age, with farmers who can be really depressed. We've had two who have committed suicide* (Roxy is quiet here with a sense of sadness as she recalls these families).

Annette: *It's a reality* [here] isn't it?

Roxy: *It is a reality and these men hadn't come for therapy. We saw their families. But after* (2 second pause) *I think, if you stop and think and consider that farmers a lot of times, in fact most times, not always but a lot of times, come from their fathers who were farmers, and their fathers were farmers. And for them to be the ones with the farm starting to fail. I think they take a lot of that responsibility on themselves. Therefore they get very depressed…So there is an intergenerational thing too* [her clients] *had to deal with*.

Annette: *An intergenerational thing? I'm not sure what you mean?*

Roxy: *Like* [her male client's names] *were both trying to work the farm … and this young man's father was very harsh … and he wanted to try something different*...

Annette: *Almost like the handing down, the process of handing down the farm from one generation to the next*?

Roxy: *Exactly, exactly* (nods) *and there were two boys and one boy was fine but this one sort of couldn't do it to his father's satisfaction I think. And I know*

in suburbia [Melbourne] *there is a lot of families but I don't think there is as much intergenerational or trying to work together as in rural*.

Annette: (Later in same conversation)… *And it is interesting when we are talking, considering both of us are reasonably feminist, that we are talking he's and men, because that's predominantly what you have found in practice*? (Question asked to Roxy. We both look at each other). *That it's still men running the farms*?

Roxy: *I think so. The wives are allowed to go out there and run themselves ragged…milking and some of them drive tractors and doing all sorts of things. But when the farm gets passed on and the person in control normally isn't the lady. She is just the free help a lot of times from my experience.*

Annette: *You've worked with clients and you have noticed a pattern, is it that intergenerational thing again? That the farm goes from male to male or is it something to do with the traditions of maleness? Not sure what you mean by that, I am thinking*... (I look at Roxy).

Roxy: *That they are in control?*

Annette: *Well, I'm wondering, are we more male oriented, is it traditionally more male oriented?*

Roxy: *I think we are. I think when you talk rural that is one of the things. I think it is more male oriented*…

Annette: *And that must have implications on practice then? What does this mean when you are working with these people when they come in? When a rural family comes in. What does it mean for your practice?*

Roxy: *Well it means that firstly you have got to make sure you join with dad or the farmer…You will find the women are good at joining, they're good but the men. If you want them to keep coming you have go to join with them. …You also need to try, I think, give the women a little bit of power, a little bit, been dropping in gently, you know "Well what does your wife think about that"?*

Annette: *That's the feminist empowerment stuff in family therapy isn't it?* (I look at Roxy).

Roxy: *Yeah* (nods).

Annette: *And it wasn't until you talked about the intergenerational, that we started talking about the maleness, whatever that is. This is almost like it is slightly more conservative perhaps* …

Roxy: *In the rural?*

Annette: *Yeah*.

Roxy: *You see a truck with "Save the environment, Doze a greenie", or, don't laugh* (Said with humour to me as I react with a smile to this saying as find it funny. The meaning of these stickers is to "*doze*" or bury those "*greenies*" who are campaigning for environmental conservation.) *because they are horrible stickers on their trucks. There's more than there should be and I do know when you talk to farmers, they are also a little bit, and they may have reason to be, "Oh what would anyone know if they are not on a farm"*. (Roxy speaks in a different tone here, while repeating these and following farmers' comments). *Like there was an issue once where we stopped cattle grazing in the high country. Well [some of] the farmers were, "What would politicians know". So I think there is an awareness in the country, that nobody understands rural like rural people. And therefore they get a little bit, on their high horse particularly when the government makes the rules like that. And when they had the bushfires, "Well that's because the cattle went in the high country"* (New tone used again)…*Because for generations they had run their cattle in the high country…And then it was suddenly stopped. They are very big on tradition too.*

Annette: *And…I was going back to thinking about your intergenerational thing. There is something, some meaning in rural about...I don't know, having their own way. I haven't got the right words, I am trying to catch what you are saying, and something about intergenerational and you don't understand the rules unless you are rural?*

Roxy *Yes*.

Annette: *But here's something more that that isn't there? There's almost a little edge …there's something I can't quite*…

Roxy: *I think it is, that comes down to a certain pride in they know how to deal with the land. They have lived on it there all their lives... So they don't want laws that they can't take their cattle up* [To the high country]. *They are more or less saying we're not damaging it. And there is you know, "We've lived on this all our lives, we know how to take care of the land". And nine out of ten times they do. I think that's it. There's a big thing, its tradition and knowing. Knowing the seasons and what your land can hold.*

This issue remains controversial and relevant today, some years after Roxy's interview. The Victorian Cattleman's Organisation continues to campaign for high country grazing, citing it as beneficial to reducing the risk of bushfires. An example of this is the photograph which follows:

Victorian mountain cattleman's' mobile meeting advertisement, on public display upon the Princes Highway, Traralgon Township, 16th October, 2010 [Digital photograph].

Roxy adopted a new tone in repeating comments from these farmers, illustrating the performative nature of her narrative. Roxy's use of expressive language (Riessman,

2008), to mimic her perception of how these farmers might speak these words, enticed me as her audience to listen more deeply to what she is saying. My attention was drawn to this part of her narrative during my analysis because of how she performed this part of her story. I sought to deepen my analysis of this section of her story in a gently deconstructed (Derrida, 1980) or 'disturbed' understanding of the significance of this section of her story. I asked myself what perspectives were being privileged here in Roxy's re-counted story of farmers' access to Victorian high country land for cattle grazing? The farmers Roxy describes call upon their history of traditional ownership and care for the land they live and work upon in current times. There are however other previous histories that are not spoken of by them. These other histories include those of the Indigenous peoples of the high country, the Bidwelli tribe, who were the traditional owners of this land which was taken from them during European settlement. This was also a time of massacres of Indigenous people by settlers in the Gippsland region (Gardner, 1983). This is an important counter-narrative of Indigenous peoples traditional land ownership of the Victorian high country; it challenges the prevailing narrative of farmer's ownership of the Victorian high country land, based upon their traditional use of this for grazing.

Roxy's narrative highlights how the rural landscape impacts upon rural family therapists and the families we see professionally. Geography shapes farming families lives, identities and the issues they bring to therapy. Traditional perceptions of rurality, which understand farming as a predominantly male pursuit, devalues women while creating gender issues to be addressed within therapy. In addition, the prevailing narrative of Victorian high country land being traditionally owned by farmers, marginalises the historic ownership of this land by the Indigenous Bidwelli tribe. Rural family therapists are challenged by these perceptions within our rural practices. We are required to be therapeutically sophisticated in our engagement with rural families, understanding and acknowledging multiple understandings of rurality for clients and ourselves.

5.3. Sigmund's story: Lifecycle of land.

For individual interview participant Sigmund, rural means an attachment to the land for the families he sees which shapes their attitudes to life and any difficulties they

face. He describes his rural farming clients, "*Cow cocky farmers",* as having a different *"Mindset",* where there is:

> Sigmund**:** There's an *earthiness about them that emerges out of the lifecycle of the land and the seasons, and one's dependence on nature. That's quite unique. It's more pronounced in the rural from the city, urban areas. But I don't see too many farmers, except when there's a crisis or death, or something like that perhaps. But there's a "Suck it up and get on with it, that's what life is"* [Attitude]. *So there's a greater acceptance of those sorts of things that city folk don't share.*
>
> Annette**:** *The few farmers you have seen, the "Suck it up and get on with it" ones you spoke about…What does that mean? When you are seeing "Cow* cockies", *or when you are seeing these "Earthy" types, what does that mean?*
>
> Sigmund: *I suspect in some ways the work of people accepting what is, a little bit different and them in moving towards change is a little easier. You know "Well it happens and things break and you fix it. And you get on with it and try and make the best of it" provides that sort of greater degree of openness, I think.*
>
> Annette**:** *For rural people*?
>
> Sigmund**:** *For rural people, because shit happens you know* (Laughs).
>
> Annette**:** *Literally if you're a 'cow cockie'* (Laughs with Sigmund).
>
> Sigmund: *Yeah, cows die and you know, you lose some in calving and you know you get on with it. So there's that, in some ways greater sense of independence and doing things. Fixing things for oneself, that is suggestive of greater, when they are stuck, a greater degree of openness to change and what might they do about it…There's that sense of, 'It's down to me to fix it', and that may be part of, sometimes there is a reluctance to seek help. But that's beginning to change that when, whenever* [I have] *seen farming families who have needed help they are open to that. They're not, I don't like the word resistant, but there's an openness and, "Yeah we need help here", and a*

greater openness to "What can I do about it? What have you tried already" sort of thing.

Working with rural families who have an attachment to the land influences how participants undertake their therapy practices, so that they can understand and engage with these clients and communities. An understanding of rural identities is important for both families and family therapists within rural contexts to enhance their therapeutic work together. Sigmund's narrative draws attention to an important aspect of this therapeutic work with farming families. Many rural families have a connection to the 'lifecycle' of their land, creating an attitude of understanding and acceptance of life events, such as death. This attitude also includes an openness to change which is therapeutically useful for therapists. Transferring this openness to change, from rural families' lifestyles into their conceptualisation of problems they bring to therapy, creates opportunities for therapists to immediately engage and work more effectively with them.

I now present sub-themes from participants' stories, of the challenges we face within our rural practices. These practice stories align with a prevailing metro-centric narrative of the limitations of rurality. Analysis of such narratives intensifies the development of a richer, fuller picture of practice issues faced by practitioners in their everyday lives that my literature review alone could not portray.

5.4 Isolation, travel and access to professional development

Roxy: *I'm a little more isolated than down in Melbourne… Kind of left to yourself more is my way of thinking. You don't feel maybe as connected as you would down in Melbourne.*

Sigmund echoes this isolation for therapists:

Sigmund: *That's a fairly standard issue of isolation in the rural context; it's not just for the families we work with, but for the workers' access to training.*

Other participants, Audrey, Alana and Julia also speak of their professional isolation within their Tasmanian group interview.

> Audrey: [We do not have] *a lot of variety of services* ... [This] *means less access to professional colleagues and their ideas ...* [Than] *when you've got more services or more people within the service ...* [In] *bigger places you get a lot of crossover and people coming ... that cross-fertilisation thing.*
> Alana: *The actual sustainability of it when you work often in isolation ... it takes effort to actually maintain and sustain* [myself]

Despite the relative closeness of her practice to metropolitan Melbourne, Roxy describes access for her, or any rural family therapist or counsellor, to professional development as a significant commitment because of the distances and expenses involved:

> Roxy*:* [We] *have to go all the way to Melbourne, which is two hours there and two hours back. So if it is a two day seminar you've got to pay, you know, accommodation, meals, so it's, I think, a big commitment to rural family therapists to actually go to professional development.*

This limited accessibility to training, support and ongoing professional development for rural family therapists is also repeated by Sigmund and Eleni. For Sigmund, the problem is the distances rural therapists have to access *"Training and support"* and a "*Professional development programme"* in Melbourne is a problem*.* Eleni likewise notes the need to travel to Melbourne to access "*Support and knowledge around family therapy"* as well as to engage in networking opportunities that are not always available in her region. For Jacqueline travel is also a significant issue for practitioners. She describes her own times of lengthy travelling:

> Jacqueline*: So when I started it was three hours* [Driving], *by the time I finished it was two and a half hours with the new highway, but while they were building the highway it was actually about three to four hours* [Each way]… *The drive when I'm tired is too dangerous ... I think I'd be dead if I was doing the back run because in winter it's treacherous ... I had two lucky escapes.*

Participants' stories identify with a prevailing metro-centric narrative of the limitations of rural practice. Issues of isolation, travel and access to professional development are highlighted because of the impact these have on participants' therapeutic

practices and are consistent with my literature review. These issues remain a concern for rural practitioners, and as such require ongoing rural health policies and strategies to address them.

5.5 Rural and urban family therapy practices: Differences and similarities

In terms of her own therapeutic approach to family therapy, Roxy doesn't see any differences between the practices of rural or urban therapists, saying

> Roxy: "[*I'm*] *not sure where there's a lot of difference in practice, doesn't matter whether your clientele is a farmer or a lawyer you still do your best*

Where differences and difficulties do occur for Roxy in her practice is when she needs to refer clients on "*to other services, other agencies, even other therapists sometimes*'', as there are few options for her in her rural region. She says of these limited options for referral:

> [*The*] …*pickings are sometimes pretty slim in the country ... You don't know the therapists in the area terribly well because you, you don't, you are not sure who to send them* [clients] to.

Other participants describe similar practice experiences to those expressed by Roxy, in terms of limited referral options for family therapists working in rural regions. Julia sums up her dilemma of a lack of referral sources for her families in her succinct question*:* "*Where else do you send them* [families]?" For James, work in a rural setting is done with *"very limited resources".* His professional colleague and focus group member, Anna, also describes her limited referral options for clients and families when looking for support for them. From her perspective as a referring professional, she asks the question, *"What other options are there for me living in a rural setting where there are no other psychologists I can easily access?"* Anna also reports to the group her feedback from her clients on their limited options to be referred on for additional support unless they can finance it themselves. Her clients have said: "*So yeah it's a choice, pay or don't get service".*

Other participants, Sigmund and Eleni, see no difference between presenting issues for families in rural, compared to urban contexts:

> Sigmund**:** *We all face the developmental challenges, you know, midlife crisis, issues of retirement and dealing with kids. That's somewhat universal.*
>
> Eleni*:* [Rural family therapy practice] *is no different to city family therapy practice, I think the skills are very much transferable to a rural context or a rural setting. Maybe the issue that would be presented might be slightly different but I guess I'd like to think a lot of the work done is similar…* [She does however note] *there were some very rural issues such as the drought and isolation um, sort of farming type stresses on families".*

While some participants do not see any differences between rural and urban therapy practices, participant Jacqueline describes "*Big differences between the urban* [and rural therapy practices]". She experiences difficulties with referring clients on in her rural region, as "*There's no one to refer onto*", due to a lack of availability of other practitioners. For her this means that within her practices she needs to be able to deal with whatever issues families bring to her. Jacqueline suggests that she is required to be a generalist in her approach to practice. For her this means having a diverse, general range of therapy skills to match the needs of her clients, rather than being a specialist practitioner, providing therapy to only a small section of her community. She comments:

> Jacqueline: *I can't* [choose to] *be much specialised. I will only see this particular type of client, this particular type of issue because it doesn't work...You have to be quite generalist.*

Participants differ in their understandings of comparisons of rural and urban family therapy practices. However an area of agreement by all is the lack of other practitioners to refer their clients onto in rural regions. As reflected in my literature review, many participants acknowledge the requirement to become a generalist practitioner to meet this challenge and the diverse needs of clients.

5.6 Access to services in rural locations: Issues of social justice

Roxy describes *"A great waiting list for government mental health services*" as an access issue in her practice experiences working in a rural context. She speaks

particularly about the work she has been involved in with autistic children and attempting to access public service support for families, saying:

> Roxy*: We have a lot of autistic children and I figure they have them in the city as well. I do know for those children that get services up here, it is harder for them, bigger wait list. The government has just bought in a* [Funding] *system ... Diagnosis, speech pathologists, those sorts of things, so that will help. But … for autistic children, they do have to wait longer and I think it is harder for them…*
>
> [I know] of a *really good* service [Who] *send people out to teach you how to look after, how to deal with these autistic children but I know they have such a long, long waiting list, like years. ..So that when you find out your child is autistic and that is when you need the most, the most support, then you have to go on this humongous* [sic] *waiting list. So that's hard*.

A lack of available public transport also has an impact on families in Roxy's region:

> Roxy*: So that's the other thing we don't have, public transport. So if a client, and some of ours do, come on the train then it is not always easy to refer them on to somewhere where they might not have public transport… There are several people, our last client for instance, who if we did not live near a train station, and he's not the only one, if we did not live* [And practice] *near a train station, they couldn't get to us… I think in rural Australia, even maybe further out than here, like* [Local town], *there is no train so how, do these people would have to have their own means of [transport] and not everyone does…A lot of lower income families. I would say about half our clients are lower income and half of that again, which would be about a quarter, are really down the bottom end and don't have a car ... So they are really poor and they wouldn't come if it wasn't for ...* [Train vouchers, taxi vouchers] *to get here. I have no doubt that some* [Clients] *don't come because they can't get transport ... I think some people in our society today, there are a lot of people caught in the cracks that don't, that don't show up as needing help for services until something diabolical happens…So yeah, I think a lot of our families are isolated, even the ones that have car and income. I know we*

have had a couple that have had to ring up and say "I can't come today because I have not got enough money for petrol", so I mean it is an issue.

Anna, as part of the Gippsland focus group speaks of one small rural community that has "*No public transport*". This community is also described by her colleague as a "*Ghetto*" because of its lack of transport, resulting in the isolation of residents from nearby resources and services.

> Anna: *It's a ghetto and it's an absolute tragedy of town planning. It's the saddest thing I have ever seen.*

Sigmund also speaks of rural families having to travel to access services and that this is an expectation of living rurally because:

> Sigmund: *Historically that's what it's meant to live in the country, you don't have the services and you need to travel into the semi-urban places*".

He gives examples from the families he has worked with, who have had limited access to required specialists:

> Sigmund*: I think the issues that do come up are often related to accessibility of services, the difficulty of it, whether it's psychiatrists, whether it's the mental health teams, whether it's appropriate paediatricians, you know diagnosis, assessment ongoing treatment. I hear stories of six to nine month waiting lists for people to see specialists so I think that's a major issue.*

Sigmund suggests that there has been a loss of "*connection*" for families to their rural communities and that their "*connectedness to a community has dissipated*" over the past "*fifteen to twenty [years]"*, due to restructuring changes in rural communities. For Sigmund, these changes include:

> Sigmund*: the decline of churches, school system and the restructuring of the schools, closing of banks etc., those sorts of community units or organisations that gave isolated families a sense of connectedness and cohesion to a community.*

While some "*cohesion*" remains in communities in the form of people meeting and relating together around *"football and netball clubs",* Sigmund identifies that there remains a lack of access to services and opportunities for young people in particular. He observes:

> Sigmund*: Something that does come up from time to time is young peoples' access to services. There's nothing here for us, no work, there's no entertainment facilities, and you got to go into town to get it, whereas in metropolitan context you hop on a bus.*

Mark gives an example from his own extended family of issues with accessing medical services after family members had moved to a rural setting:

> Mark: They had *"Gone bush ...* [an] *hour's drive from nearest little town ... where there might be a GP* [General Practitioner] *occasionally"*.

A member of this family then required medical help and the rest of the family experienced significant "*trouble*" in accessing services due to the distance they were from a larger city. This family:

> Mark*: Had a major crisis with their daughter who developed a most unusual disease, she almost died, she was wrongly diagnosed .She finished up in the Brisbane Hospital near death for something like two weeks and it just bought* [sic] *home to me, I was thinking about family therapy when I was up there with her, and the distances.*

Mark describes this family's circumstances as complicated by being "*quite poor"* as a consequence of "*coming through the drought".*

Rural clients and their families face a multitude of challenges in accessing health services and specialists, including family therapists. Geographical distances to available services are a significant barrier to many. Poor families may either, not have a car, or not be able to afford to buy fuel to drive their vehicle if they own one. When these factors are combined with a lack of public transport and poor town planning, many families struggle to access services. This is a significant issue of

concern for participants, many of whom find themselves advocating for services on behalf of their clients.

5.7 Cows, “It’s the cows”

Roxy ends her stories of practice experiences by reflecting on the focus she has on doing therapy no matter the setting, rural or urban. Roxy’s words provide an apt ending to this Chapter as they return readers to the needs of clients, which are foremost in her mind as a therapist. Her focus is on her clients whom she sees as similar in both rural and urban settings, despite her previous discussions of some of the unique issues of living and working rurally. Of her own and her colleagues’ practices she says:

> Roxy*: We just do therapy. I just do therapy and I don’t stop and think ‘Oh is this rural? Oh, I should be doing if differently?’ Just what comes out of you, but when you stop and think about these* [Research] *questions and really think about them you then, well, there are some things that are different* [In rural settings].

One example of this difference in rural locations is the allowance that Roxy has learnt to make for farming families when making therapy appointments with them. She says:

> Roxy*: You have to make special times for some people because they can’t really leave the cows sitting there waiting to be milked, and so you do have to make some considerations.*

From these considerations Roxy has developed an understanding of the rural work and lifestyle of farming families. She now considers the farmer’s cows and their requirement to be milked and the times required to do this when arranging therapy appointments:

> Roxy: *Cos we’re rural you have to make time for the cows ... You have to change your diary. It’s the cows, you know, and I love cows.*

5.8 Chapter summary

Within this chapter I have presented participants' experiences of their rural family therapy practices through their narratives of rurality. How participants understand the rural settings they live and work within, and the relevance of this to issues clients and their families bring to therapy has been described. For example, clients experiencing the suicide of a family member related to the economic failure of their farm. The rural landscape shapes how participants see themselves as therapists and people. Many of my participants' stories are consistent with health literature that views rurality traditionally. That is, the limitations of rural practice. However an integral part of these same narratives is the presence of a beginning of a counter-narrative of rural relationality which counters dominant understandings of rurality as a deficiency. Rurality is instead understood as profoundly relational, intensely connecting people to their rural landscape. For example, "earthy" farmers in tune with the "lifecycle" of their land creating an openness to change useful in therapeutic work. I continue to explore contradictions within participants' narratives of rurality within my next chapter. I deepen my analysis to unearth further narratives of rural resistance and resiliency.

Chapter Six

Rurality as resistance, resilience and connectedness

> A problem does not exist, apart from its solutions. Far from disappearing in this overlay, however, it insists and persists in these solutions (Deleuze, cited in May, 2005, p.85).

6.1 Introduction and analysis

The theme explored in this chapter is that of the participants and my resistance to dominant understandings and narratives of rurality. All of us identified with these prevailing narratives, understanding rurality as challenging to our practices and identifying with the deficiencies of these challenges. However, we also embraced alternative understandings of rurality *at the same time*. My participants share practice stories of experiencing the damaging impact of prevailing narratives of rurality upon their clients' lives. These stories describe our resistances towards prevailing metro-centric understandings of rurality, motivated by a collective social justice agenda. Our resistance reinforces and energises our rural resilience, adding depth to a new counter-narrative of understanding rurality as relational, which continues to emerge in this chapter.

My approach to analysis in this chapter continues to be a layered one. Building upon my previous dinner party conversations with Catherine Riessman (2008) and Jacques Derrida (1982), I am now joined at the dinner table by French philosopher Foucault (1980;1982; 2000) to further explore participants' narratives during my second layer of analysis. Foucault and I discuss my understandings of his concepts of power and resistance, and normalising practices for their value to my analysis. From this conversation I come to understand participants' narratives as their stories of resistance to dominant understandings of rurality. I continue to 'disturb' (Derrida, 1982; St. Pierre, 2000) participants' practice narratives to heighten our understandings of rurality as relational. This understanding values the connections we have to each other as family therapy professionals, as well as with our clients and their families, who seek professional help from us. Participants and I share

stories of our hope and commitment to clients and communities, as alternative understandings of rurality as relational from our substantial practice experiences.

6.2 Tasmanian stories of resistance

Understandings of rurality as relational created the context for my participants' therapeutic practices with clients and professional colleagues. The Tasmanian small group participants, Kitty, Julia, Angel, Alana and Audrey speak of their identity as rural family therapists and social workers, practicing within a social justice agenda, before discussing stories of significance to them. In sharing their identity and commitment to social equality, participants and I are drawn together, creating a safe space to tell our stories of resistance.

I begin with this group's narratives because of the powerful use of expressive language, body language and emotionality during our discussions together. Their stories are the most detailed of all my participants of the bone deep injuries of social justice upon their clients and their families. A steely determination is revealed in their collective narrative of outrage at these events, which becomes palpable in the room.

The Tasmanian group gather in Kitty's house by mutual agreement. We sit together (Including Kitty's cat) around a table, sharing food while we talk together.

> Annette: *So what is family therapy practice for you? What would that look like, what would you be doing?* (Group make full eye contact with each other, smile and then look thoughtful. After a short pause Angel begins her reply).
>
> Angel: *Working with the family system and um the framework and models*. (Everyone nods in collective affirmation of this key element of their rural practice) *I guess having the background in…* (Pause 2 seconds. Group murmurings of mmm in agreement, encouraging her to continue)
>
> Julia: (Immediately joins in as Angel finishes her sentence) *Looking through those lenses, isn't it at the whole,* (Group again nod in agreement all of whom are intently following her conversation with full eye contact) *You know, the dynamics of the family unit* (Julia waves her hands in a circular movement to

demonstrate these dynamics as movement and fluid. She also makes eye contact with each group member as she speaks turning her head to do so) *and um, you know because usually you are presented with one client you know that's using the intake model. One client comes and so then being able to step outside that pathologising the individual and looking at what is going on around that one. And who else can we enlist, where are the strengths? Where are the weaknesses within? You know what's going on?*

Audrey: And *um, I feel for me* (Audrey gestures with her hand while talking. She places her hand over her chest as she says *"For me",* emphasising the importance of this statement which comes next to her) *it's more, you take a little bit more of facilitator's linking role, rather than an expert role*.

Angel: *A process of joining with the family* (Uses hand gestures to indicate this) *and then be asked to join in with the family and work through the assessment.*

Kitty: *What's happening between the relationships? What are the things that are happening between*...? (Stops as Alana finishes her sentence for her)

Alana *The spaces between*.

Feelings of warmth and empathy radiate within the group as we interact, bonding us together. This in turn, deepens our trust and respect for each other enabling us to now explore practice stories of resistance in a mutually constructed place of safety. The telling of stories of resistance would be a professionally risky pursuit outside of this group. However, our shared social justice agenda inspires us to do so. The group therefore seizes the opportunity to discuss these stories, within our research conversations.

6.2.1: "Get them off the books"

During our small group discussion Audrey, Angel, Alana, Julia and Kitty speak passionately of the marginalisation of their clients and families in the restructuring of referral pathways and funding to professionals for counselling and therapy. Changes to funding arrangements to non-government agencies, requires these agencies to

adopt a new Victorian based referral management system. This system centralises all referrals and mandates new assessment procedures, which then direct clients to appropriate agencies. As part of this new system agencies involved have been directed by their managers, who in turn have been told by the Tasmania Department of Human Services, to decrease the number of long term families they support. All Tasmanian group participants have serious concerns regarding the ethics involved in this new referral system.

Alana begins her story by telling the group about the devastating impact this new system has had on her, speaking in an angry tone:

> Alana: *We now have to work with what is called the Gateway service* (All the group members look at Alana as she speaks, listening attentively).
>
> Julia: *Ah*, (Speaks loudly) *you're under Gateway*?
>
> Alana: (Directed at all the group) *You're under Gateway as well*?
>
> (Some group members nod).
>
> Julia: *No, no* (Shakes her head).
>
> Alana: *Well I've had my meltdown. I'm ok, I've had my own counselling over it, that's how bad it was* (Says this in an indignant tone. Group members remain attentive).
>
> Julia: *So our gateway is the Victorian one. Victoria went to a Non-Government service delivery, pre-child protection kind of intervention. Gateway is the Tasmanian model implemented by the same guy who set up the Victorian model* (Says this to me as an outsider to Tasmania to help me understand their model compared to Victorian system I'm used to).
>
> Annette: *Ok.*
>
> Alana: *Which doesn't work in Tasmania, <u>as far as I'm concerned</u>* (Says this in an increasingly loud angry voice. Underlined words are said with strong emphasis. Alana raises her arm above her head to call attention to herself as

she says the underlined words. All the group nod as Alana says this, and there are murmurings of mmm by many to show their support and agreement with what she is saying. The collective mood is one of growing indignation. Julia turns to face Alana more fully).

Alana's emotions and words catalyse the group into a long conversation about each of their understandings and experiences with this new referral system. The section below contains examples of our conversation which illustrates the growing discomfort of the group at what we perceive as an issue of social injustice.

Annette: *So you've had a system inherited from another state, another region bought to here from*?
Alana: *A big city region I'd say with lots of child protection services and lots of child protection clients and families that have been, um, involved with services over several years and they have been told to* <u>*get them off the books*</u> (underlined words said with <u>emphasis in a strong angry tone</u>). *I'm sorry* (Offers apology to group for her strong use of angry tone, they nod in acceptance of this) *but that's how I see it….we now have an intake process which is ten pages long instead of a chat over the phone, we have a computer programme that every minute of every day has to be out into …from the intake process you then have to fill in a form that goes to a meeting where twenty, up to twenty organisations* (repeats this to make her point firmly) *who are part of Gateway sit and talk about your counselling this client.*

Angel: *And a lot of families just will refuse the referral if we, from our point of view, if we are true to informed consent and say I want to access one of the agencies counselling programs. But this is the intake process, and this is who will have your information. And they say no.*

Alana: *They say no way.*

Annette: *I don't blame them*

Group members nod and say no together, affirming my statement and its fit with social justice agenda.

Alana: *So people sit around and I give them, there is a score. I have to give them on this sheet* (Rating given to her client on a referral assessment rating scale.).*If your score is not high enough you* [her client] *will not be able to come and see us.*

The group is galvanised by this part of the conversation. They talk over the top of each other all at once. I am unable to hear all of their comments. They speak of how they perceive their clients and families are treated by this new system.

Angel: *Nobody, they're nobody*.

Julia: *They don't rate*.

Angel: *You have to get your own help*.

Annette: *So help yourself until you are 25*? (Referring to young people having to help themselves until 25 years of age)

Kitty: *But that's essentially what child protection is*.

Group: (Together and with emphasis) *Yes!*

Later in this discussion, Angel calls the group's attention to issues of risk to clients in the new referral management system. Her emotional distress and use of expressive language while speaking quickly engages us in listening to her.

6.2.2 "Gut-wrenching" risk to families

Angel: *There's* [a] *level of risk in the families that are in the Gateway service* (Angel says this quietly in a determined tone. The group turn to Angel and listen attentively).

Annette: *Really*? (Said in an enquiring tone to illicit more information).

Julia: *Yes*! (Said loudly to register her agreement with Angel).

The group become animated in their conversations, talking over the top of each other. I find it difficult to hear all their comments. I come back to Angel's statement to

try to clarify with her what she meant. I pick up from the group comments that they are questioning this system. Angel's mood is one of sadness and I sense there is something important she wants to say.

> Annette: *So it's questionable and?* (Said in an enquiring tone to encourage Angel to speak more).
>
> Angel: *Yeah, and I've had cases with extreme domestic um violence and family issues. Mental health issues in the family. And it's um, someone with a, you know, TAFE diploma who is providing the intensive family support. And in one family that I'm quite distressed about, that person has colluded with the perpetrator of the violence in the home.*
>
> Annette: *Oh Angel* (Sympathetic tone in recognition of Angel's distress. I call upon my knowledge of Angel as an experienced and ethical professional to understand that this would be a devastating incident for her, given her social justice focus).
>
> Angel: *It's gut-wrenching*

Angel's voice has a slight tremor as she says this reflecting her distress. Her quiet voice contrasts with her strong emotionality which pulls the groups attention to her. In my visual analysis I see that we all now look at her. While no one speaks there is a sense of camaraderie as the group witness her distress, and share feelings of outrage at the injustice of this situation for her clients. The undervaluing of experienced professionals practice wisdom, has meant many families have been assigned inadequately qualified staff to work with them in the new Tasmanian Gateway referral system. The complexities of risk, which can be subtly hidden within rural contexts, may be overlooked by staff without adequate training in recognising and managing these. Angels' quiet distress draws us into this part of the story as witnesses to this issue of social injustice. This discussion scaffolds those which follow, as we move deeper into our own emotions unearthing significant principles which underpin our therapeutic and professional practices.

6.2.3 Taking up A call to resist? Collective outrage?

In a later stage of this conversation I ask the group to discuss an undercurrent of emotion that I am experiencing in their conversations which I don't understand. I sense there is something important happening in this narrative that I can't quite grasp. I feel an emotional tone I can't identity growing within the group, and am unsure what this means. I ask Alana to clarify what she has just said about clients being excluded from services under this new referral system:

> Annette: *So it is becoming quite exclusionary? Like, "I'm sorry but this is your service and if you don't go there you won't get service at all". And it's almost like there's a tone of something else as well? I don't know what. I'm picking up like a tone, like almost like, you deserve this*? (Question to all of the group said in an enquiring and curious way.
> Group all nod in agreement).
>
> Annette: *You know there's something wrong with you*.
>
> Alana: <u>Not only that</u> *Annette,* <u>not only that</u> *and it's, "Don't come here expecting you will get any help. Or, "If you don't do as we say", it's really big brother, "If you don't do as we say", you're seen as ah oppositional. And ah, "That will be put on your file"* (Alana says this firmly, emphasising her point in her repetition of words, with underlined words said with extra emphasis and anger).
>
> Kitty: *That sounds like a similar thing to housing* (In the context of clients being refused access to housing support if have they declined offers made in the past).
>
> Annette: *And that's punitive too isn't it*? (Said to Kitty).
>
> Kitty: *Yes* (Said with conviction). *And I said to the lady who came to talk to our team. Like you raise that, about like, "How do you expect some of these really complex families to be able to meet that because there's actually a percentage of the population that just won't, won't be wanting to"? And again*

it's about um, creates a distinction over those who are deserving and if they are compliant, well yes, they are deserving. But if they're not well.

As participants speak of their resistance to a new referral system, they are performing these resistances in a narrative dialogic/performance sense (Riessman, 2008). Witnessing each other's narratives of resistance emphasises the importance of these practices for individuals, while affirming the group's commitment to principles of social justice. A tone of collective outrage has grown in response to this part of Alana's story, as the group identify with her anger at the perceived exclusion of clients from their services. Our antennas of social justice are quivering as we recognise issues of marginalisation and exclusion from relevant services for our clients that need to be addressed. As skilled family therapists the group call upon systemic thinking practices to understand how these issues of social injustice have been created. By conceptualising our clients, ourselves, and our rural communities as a series of ever widening systems we become aware of how the new Tasmanian referral system was instituted.

6.2.4 "Audrey's resistance: Your model won't work here".

Audrey: Instead of just going to Victoria and saying, "Here is a great model, let's, lets now just dump it in Hobart. Let's dump it. We have a unique kind of demographic and we don't have big teams or anything like that. Well yep, we've still got quite a significant population. People don't always think that because we are so spread out over all the distances we cover. And um, all sorts of practicalities of um (Three second pause while thinking)

Annette: Local contextual knowledge is about?

Audrey: Factors that, yep, yep.

Angel: But even within the state, the North West, the north south are very different and we have had to battle that in in our agency. Which um, "We want what Hobart's doing, we want it to be done everywhere else" (Angel mimics the voices of her management who have directed her to do this). *And you know, that's not going to work here. So when we talk about our interface with*

families and our difficult clients we've had to stand firm against, "No your model won't work up here, we'll create our own model" (Angel speaks passionately while saying this, increasing her volume in her final comments).

6.2.5 Julia's resistance: "Making it fit"

Julia picks up this theme of a lack of respect of local contexts. She draws the group's attention to how she makes her work "fit" through her family therapy practices and relationships with her small community:

> Julia*: I think I'm really fortunate where I am working currently in a small, small rural community ... I think the family therapy part of my world just pulls it all together beautifully. You know that the opportunity to maximise resources that we have. To build really strong relationships with, you know, the school, with the community house and with myself. And that's about us really (*Laughs as she finishes in acknowledgement that there are only three strong resources). *But that's good.*
>
> Annette*: That's three resources?* (Said in an enquiring tone to clarify).
>
> Julia*: Yes!* (With humour)…*When I say the school I mean particularly the school social worker because she covers the outlying schools as well. So by building really strong relationships in that sector allows us to work collaboratively and respectfully around, you know, the community and it's so powerful to have these solid relationships … Working regionally you know that it has its limitations. But we have so many strengths in that we don't get hooked into all that, when there's multiple services and they are all having those discussions …*
>
> Alana*: Crap!* (Said with humour).
>
> Angel*: Good word for it.*
>
> Julia*: Because they can't be bothered coming out to us, so we make it fit for ourselves.*

Annette*: Ah, so even in the isolation, if you've got people you can network with you can become a really supportive community?*

Julia*: Yep, they are there and it's just about, well I mean, I think that we would all say that* (Pause two seconds while thinking), *you know, unless we work together, we each work in isolation. (*Group enthusiastically agree and nod as she says this).

Julia*: And isolation can be fine but you know it gets a bit lonely (Laughs) and it gets, you know tough you know. But by working collaboratively we become a much stronger force. You know, we can do group work together. We can do family consultations…We can provide much more cohesive service to families.*

Annette*: It's almost a synergy when you are together?* (Said as a question to Julia).

Julia*: Yeah.*

These sections of Audrey and Julia's narrative draw attention to understandings of rurality as contextual and relational. All rural communities are not the same. Local contexts need to be considered in the development of new referral systems to ensure these systems are relevant and accepted by local communities. Understandings of rurality as relational can provide guidance in the development of new referral systems, by emphasising the strength of locally established relationships between professional groups. These practitioners have developed their relationality out of necessity, in response to their geographical and professional isolation. As such, they have bonded strongly as individuals, creating a collective rural resiliency. This synergy provided the foundation upon which Julia and her colleagues were able to build local support systems for families that were accepted by these communities.

Angel builds on Julia's previous conversation inviting the group to consider the value of their connectedness in their continued resistance as family therapists in isolated rural communities:

Angel: I'm going back to pick up on what Julia said with the relationships. There are enough of us in the (Name of her region) *who have worked in those agencies long enough that* (2 second pause while she thinks) *that our gateway work with these families, we can still have those connections. As long as we don't have to interface with Gateway. That we can work to get a family support and that's what we have to do now, without going through Gateway. We'll use those connections so we have to work in spite of.*

Annette*: Try and work around the system that has been imposed on you? It's almost like going underground.*

The group all laugh at this expression.

Annette*: Instead of the French underground you have become the social work underground?*

Angel*: And dig a tunnel to your office and say…*

Alana*: At least you can do that Angel, I can't.*

Angel*: No, because you're a part of it, makes it more difficult for you.*

The group come back to use this language of going "*underground*" later in the conversation, demonstrating the dialogical nature of our conversation, (Riessman, 2008).

Kitty*: …We're having a servicing crisis really, where you have to go underground in order to be able to work in the way you want to and having those conversations ... "It's not ethical what you are asking me to do because I wouldn't see a family for an hour and then give them a mental health diagnosis without doing a comprehensive assessment by my standards. I want to do it in context and I'm not going to be doing it that way. So if you want to do it that way, you want to ask another clinician ... but I'm not doing it that way". The very least … what I hope is to be able to do is the relationship thing … Somebody comes and they feel contained, safe and heard and sometimes I have to resort like right down to that basic level to feel that I'm doing something, or that it's worthy of anything.*

6.2.6 Building rural resiliency from resistance

Audrey adds to the group discussions of our understandings of rurality as relational. She shares the deeply personal meaning these relationships have to her professional practices:

> Audrey: *Sometimes it's also about quality and not necessarily quantity as well. And I think that even though there's a very small pool of people who um, I've found that are um likeminded and supportive and um* (Thoughtful pause for three seconds) *especially in a small community because you know each other professionally as well. And you know this group is so intimate and has been so intimate, I think that really strengthens relations as well. Not just professionally but personally as well. And I think that um* (Three second pause, looks thoughtful again while thinks) *that level of trust, you really build. And um yeah that really keeps me motivated. And at time when I feel like I'm losing a battle or what have you, um, even though we don't catch up as often um as what I would have liked.*

The group all loudly laugh together and look at each other, smiling in their mutual recognition of the importance of their connection that Audrey is articulating. Unable to hear words clearly as they talk together all at once.

> Julia: *Which is what we are changing today.*
>
> Audrey: *And passion and um having someone that you really respect and admire, who are like minded as well. There like that is camaraderie and that um, yeah passion*.
>
> Annette: *My heart sort of glows because I hear you guys and then I hear guys I know in Gippsland and they say different words but the same thing. It's like we feel the same. We are isolated but again we are really close, have worked together. So we have these connections…How do we keep those connections and grow them a little bit too somehow* (Said to all of the group as a question. Julia and Angel quickly respond before I finish).
>
> Julia and Angel (Together) *That's right* (Said with emphasis and conviction).

Annette: (Continuing to speak) *Find some ways of bringing more rural people together? Because there's something, some synergy in bringing them together?* (Said in an enquiring tone directed at all the group).*Something happens, that's the bit that inspires me.*

Julia**:** *And I guess that's at a couple of levels…I'm in isolation in that family therapy model but I literally pine for these opportunities when we can get together and bounce around ideas and you know, reflect on particular struggles.*

Audrey**:** *Because it can be hard.*

Julia: *It can be really hard.*

Audrey**:** *And demoralising and exhausting. And um, just having someone's sympathetic ear and who is able to confirm what your thoughts are about something. Or kind of really just back you up...*

Julia**:** *Speak some language that opens another door that you understand.*

Audrey**:** *absolutely.*

Julia: *You understand, you're connected*.

Audrey: *Absolutely. I think that is really really valuable.*

6.2.7 Power and resistance: Alternative understandings of Tasmanian participants' stories

I engage in a dinner party conversation with my guest Michel Foucault, to broaden my understandings of his concepts of power, resistance and normalising practices. I then utilise these concepts to deepen my second layer of analysis of Tasmanian participants' stories.

Foucault suggests his work is useful to feminists such as myself, in understanding power. He describes power to me as pervasive, existing within, "social, institutional,

and interpersonal relationships, in addition to operating at the level of the law and the state." (Foucault cited in McLaren, 2004, p. 228). Power in a Foucauldian sense therefore exists everywhere. It "flows through society in networks" (Foucault cited in Neal, 2009, p. 163). Power is also complex. Foucault (1980, p. 142) explains power as existing within "relations of power ... [which are not] a binary structure with 'dominators' on one side and 'dominated' on the other, but rather a multiform production of relations". A Foucauldian understanding of power allows us as feminists to not simply overcome our differences but rather to use differences as "a resource … to establish multiple points of resistance to the myriad of micro-level and macro-level[s] … of domination [from relations of power]" (Foucault cited in Macleod and Durrheim, 2002, p 55).

To understand and analyse power, Foucault (1980, p. 77) proposes that I focus on "[the] tactics and strategies of power" within specific local contexts, rather than large overall systems. Power, in a Foucauldian sense, is also understood as being able to both repress and liberate individuals. Power "coexists with resistances to it" (Foucault cited in Macleod and Durrheim, 2002, p 55). This concept of resistance is significant as it resides within the same place as power. Foucault (1980, p. 142) explains that "there are no relations of power without resistances ... [Resistance] exists all the more by being in the same place as power, hence like power, resistance is multiple". Foucault also calls my attention, in our conversation to not only to the concept of resistance as a means of overcoming the strategies and tactics of power, but also to what fuels or drives these resistances within individuals:

> We must discover what makes Mikhail Stren [a Socialist within a Gulag] say I will not give in … We should listen to these people … What is it that sustains them, what gives them their energy, what is the force at work in their resistance, what makes them stand and fight? (Foucault, 1980, p. 136).

Foucault, reveals to me that "the primary ways in which power operates on individuals is through norms" (Foucault cited in McLaren, 2004, p. 228). Power is also "productive … It normalises them [individuals] according to an ideal of what a modern individual should be" (Foucault cited in Neal, 2009, p. 163). In a Foucauldian sense, power is used in a process of normalisation, whereby individuals are directed into stereotyped roles or norms that are chosen and dictated by the majority who

agree with these norms. Foucault states that what is required to redress normalising practices is to firstly recognise that norms and the damage they cause do exist, and secondly to find ways to resist these (Foucault cited in McLaren, 2004, p.228). What is also necessary is a resistance to accepting normalisation practices themselves as being normal, because of the limited characteristics they thrust upon individuals. Perhaps our task is, Foucault (1982, p. 785) comments, "not to discover what we are but to refuse what we are".

I am mesmerised by this part of our conversation. Foucault's discussion of how to analyse power, and example of Mikhail Stren's statement above, galvanises me into applying these concepts to my Tasmanians participants' stories. For example, what is it that this group are resisting? What gives them their energy? What is it that sustains this group to continue fighting issues of social injustice? How have normalising practices been used on the clients and families of my Tasmanian participants, as part of the new referral management system implemented in Tasmania? What does my participants continued resistance to this new system accomplish.

From my discussions with Foucault I utilise my own understanding of his concepts of power, resistance and normalising practices within a further analysis of my Tasmanian group's stories. I come to understand their stories of resistance to a new referral system differently. Angel speaks of working together with colleagues "*in spite of*" this new system and with recognition of differences across rural locations. Kitty openly discusses going, "*underground in order to be able to work in the way you want to".* She articulates her resistance to this new referral system's requirements by declaring, "*I'm not going to be doing it that way*".

Tasmanian participants' stories, including those of Angel and Kitty, demonstrate these participants resistance to dominant understandings of rurality being all the same. Rurality is predominantly defined within a traditional Australian classification system, consistent with my literature review. A newly implemented referral system in Tasmania, based upon this classification system does not recognise local Tasmanian contexts. Tasmanian participants speak of the imposing of this classification system from another Australian state-Victoria, and that what has

worked in that rural context might not necessarily work for their Tasmanian contexts. The implications of this new referral system, for participants, is that they are experiencing decreased access to services for their clients. This is a social justice issue for them, and in response to these concerns they are resisting this new system in a Foucauldian sense.

A traditional perspective of my Tasmanian participants' stories of resistance to this new referral system, could be understood as non-conformity on their part. However, within my second layer of Foucault informed analysis, I propose participants' stories are examples of their resistances to a prevailing narrative of all rurality being the same; and the implications of this for their clients. Their resistance is driven by their collective social justice agenda as rural social workers, requiring them to fight against inequality Their resistance creates a powerful counter-narrative of understanding rurality as relational and contextual. This counter-narrative in turn, builds their resilience as individuals and as a social work collective. These aspects of my Tasmanian group's practices offer unique understandings of how these individual practitioners were able to build resiliency to sustain themselves professionally, and flourish collectively within their rural settings. Inspiration to sustain themselves is drawn for these participants initially from each other, and their therapeutic work with clients. This is an important understanding for other family therapists contemplating rural practice to consider. In addition, their new counter-narrative allows their resistance to be understood by other rural family therapists as courageous in advocating for services for marginalised clients and families. An analysis of Tasmanian participants stories as a new counter-narrative of rurality as relational and contextual, is consistent with social constructionist and systemic family theory practices of considering wider social contexts (Madigan, 1999), and narrative therapy concepts of developing alternative preferred stories of competency for our clients (White, 2007).

6.2.8. The rural environment as lifestyle choice

Other, shorter stories told by individual Tasmanian group members, highlight the connection they have to their rural environment:

Alana*: I drove down here today* [to the research interview*] and the scenery just blows me away ... So it's all about environment ... That is political here too ... There are those who work and live by chopping trees down, there are those who are trying not to have a pulp mill, so you've got lots of ... divided communities and we work in the middle of it all.*

Angel: *The lifestyle in Tassie, it suits us, we love it*.

Environment is significant to these practitioners and is part of the reason why they live and work rurally. Rural as a lifestyle choice is an important part of attracting and retaining family therapists to be considered within rural settings.

6.3 Gippsland stories

The Gippsland focus group of James, Anna, Daisy and I discuss the importance of relationships within a rural context, but from a different perspective to the Tasmanian group. Our group focuses on our acceptance and belonging as people and professionals within their own rural communities. I am part of this group as I have practiced family therapy in Gippsland for the past fifteen years. James, Anna and Daisy know each other well, both professionally and personally, having worked together over an extended time. The intimacy of their relationships is evident in their research meetings together. For example, they frequently speak the same words together at the same time while co-constructing their narrative as part of a dialogical process (Riessman, 2008).

The Gippsland focus group acknowledged that there were issues of our acceptance as professionals in the rural communities in which we work:

James: If *you are not a native to that place then, when are you really accepted? I remember, you know you had these talks about when you move to a new town. Move to* [Name of town-G] *forget it, if you weren't born in* [G].

Anna: (Says this sentence same time as James does) *Yeah*, *if you weren't born in* [G]…

James: You're not part of the [G's] *community. I might be out of line here but…*

Anna*: No, no you are exactly right. And I think with every small country town it's like that...* (Nodding her agreement to James's comments).

James*: And I suspect* [G] *is not much better…and I can relate to what you are saying, if you're not a native to the language and the interaction, then when do you really fit in?*

Anna*: Yeah, yeah.*

Anna describes further the challenges she faced in being accepted as a professional within rural communities when she took up a new role as a bushfire counsellor, following the Black Saturday bushfires in Gippsland in 2009. At this time she became a counsellor to her own community. She speaks of an opening for her into the communities she was working with, around her own experiences of the bushfires. Anna's personal experiences helped her in understanding and engaging in her bushfire counselling role with those who had also experienced these fires. She explains:

> Anna*: Although the fire didn't come to our home, we still evacuated and we still had, you know, the fear of there was nowhere to go. And there was one point when I did have to say to myself, "Well I suppose all I can do is go and grab my dad and we'll jump in the sea if there's nowhere to go". You look back at those thoughts and think "Wow, what space was I in then?"... But you know you can sort of, to a degree, be good to have gone through that myself because then I can have that, one-on-one with a client saying, "I've been there too, not to the same degree, you have but this is my experience". So they know you're not just someone coming in willy nilly that just thinks they know what's going on.*
>
> Daisy*: And it legitimises it too for a lot of rural people, because that's what they don't want. Counselling or anything from people that don't know the land or don't know what they're on about.*
>
> Anna*: Yeah, that's true…*

Daisy*: Or don't know what they are on about and that's been our experience with our rural* [Bushfire*] counsellor.*

Anna: (Acknowledges Daisy's comment) *Yeah they want to see one of their own. And to a degree having worked in a small country town, working with the people that you know, in your community, can be difficult for things. Like walking down the street and having them drag you, you know, "This is what's going on for me", or "I know such and such down the road". Happened to me only yesterday. "My cousin happens to be such and such a person". The one I spoke to yesterday, and "I know that her husband is not doing very well". You know. Oh ok and just can't say anything to them. You know but, to have to do that is really difficult. But you've sort of got that trust with them already, because you are local…*

Daisy*: Or you find people that will be in one rural community that will come to another [community] because they don't want to work with the people in that community.*

Gippsland participants face layers of complexity in their professional relationships with clients and other community members, while living and working in rural contexts. These practitioners require acceptance as part of the general population before taking up their professional roles. This acceptance instigates close relational ties to their community, creating ethical dilemmas around confidentiality issues for clients and themselves as family therapists.

6.3.1 A commitment to making a difference and a sense of hope

The Gippsland group speak together of the length of time they have been working as professionals and their commitment to their chosen practices of social justice:

Anna: *Having worked for* [One agency] *for ten years and eight for you*. (Anna Directs this comment to James, as they have worked at the same agency together)…*having spent that time away from* [Community's name], *helped me gain strength and the confidence to go back to the community* [In her later bushfire counselling role].

Daisy*:* (Directs her comments to Anna) *God that's how long you've been doing counselling work ... Took me to a completely different place .I didn't put it in context of the work you have done for* [Agency's name]. *I was looking at it in the context of, Oh my God* (Said with amazement*), that's how long you've been doing counselling work, so for me…*

Anna*: Yeah* (Nodding to acknowledge Daisy's comment*).*

Daisy: I think it talks about the commitment in terms of wanting to make a difference and giving that sense of hope that things can change and sticking with that, which both of you do really well (Directs her last comment at Anna and James, in an admiring tone while looking at them).

James*: The commitment goes both ways.* At [Name of his agency]. *I think it is easier to stay there for ten years because they're committed to their staff as well in ways other agencies aren't.*

6.3.2 "Creative connective work" and "someone to help unreel the wire"

Anna, Daisy and James discuss their practices in engaging and working with families. They speak of how their work has become more flexible and creative, inspired by unique practices of their colleagues, supported by their agency. Daisy reflects on a previous research meeting and conversation within the focus group which she was absent from. James, Anna and I have been catching her up on what was discussed at this time. She replies to us:

Daisy: *I think the interesting thing for me was the conversation about alternative environment, and the breakthroughs and things when you recognise that you can have the capacity to be that flexible ... And it's that flexibility to engage in a way that you know is going to work…I think the thing the* organisation [Her employment agency] *does for us is, it allows us to take time so that if you've got six hours funding to work with someone, it doesn't matter if it takes longer than that as long as you've committed to making that journey.*

James emphasises the importance of offering hope within his bushfire counselling and support role:

> James*: It's that pragmatism coming through, you want to offer that capacity for hope and expectation ... How do you find that balance of what you can offer and what you can, in the way of hope and I think for survivors it's a pretty good thing.*

Daisy's comments reflect the importance to her of developing more flexible work practices, and how she was supported in this by her agency. Time taken to work with clients is seen as important and valued by Daisy's agency. Workers are also implicitly valued in their ability to take more time with clients as required. Gippsland participants' comments, regarding agency support, are in stark contrast to the previous discussions by Tasmanian participants about their lack of agency support around a new client referral system. Gippsland participants identify that their agency has a clear social justice agenda, allowing them to support marginalised families, which is seen as fundamental to their practices. The commitment Daisy, James and Anna have to their therapeutic work is mirrored by their agency's social justice principles. Of significance, is the length of time these practitioners have remained working for this agency. Commitment by their agency to social justice principles has ensured just therapeutic practices for clients. In addition, it has been an important part of staff retention in a rural region that struggles to attract and retain suitably qualified staff.

Anna questions being asked within her agency about how the case management system being used for bushfire counselling is working and where the boundaries of their work lie:

> *Anna: They are starting to explore that, what is case management, how far can we go? Now it's got to the point where this same male case manager has actually gone off and assisted one of the farmers to shear his sheep because he couldn't get a shearer…Now I've felt comfortable to be able to say to one of my dairy farmers, "Well I'm not just here to help you with your paperwork mate, I can come down and help you do that fence if you like".* (Anna then comments on this farmers' response)*: "He said 'that would be great, I really*

need someone to unreel the wire… (Then comments to the group) *Yeah to be able to get to somebody in a rural farming environment, you need to be able to, to let them know that you actually understand. You can do what they're doing and you can see what's going on for them, whether it be physical or emotional.*

From Anna's comments an animated discussion is sparked between James and Daisy. They begin to talk together excitedly. A sparkling energy glows within the group as they talk together of experiences they have shared together. Anna and I listen as their enthralled audience, drawn in by their enthusiasm as they speak.

James: [It] *is more than words and more than actions, it's kind of global communication and you go and help a farmer with his fence and he's thinking, "Well she understands what I need, she's there for me, maybe she's got something else to offer"... And that's what it takes, when we have an approach where in our community work, community agency context, it's about outreach. And we're always frustrated about why outreach doesn't work because of the restrictions on it, what it takes to connect with someone, is not what we are allowed to do…*

Daisy: [If] *we look at it in context of another person we know, who works really well, who is an untrained counsellor. The connections that he's made with people have been invaluable. He goes out to the farm and does the digging, he does the whatever, and he's done it forever. He's been in conflict with the local psychologist for as long as he's been working for us. But his ability to connect with people over time ... His faith in certain people that work in the field means that those people will come and seek help that further help, when it gets to a point where he can't deal with it. And that's been really exciting to watch… I thought that we would never be able to do that because of occupational health and safety, the safety and all those types of things, so we've done some, been able to do some really creative connective work as a result of a natural disaster* [Black Saturday bushfires in Gippsland 2009].

James: *Yes, that's right. Those people* [Farmers] *don't come to your door and if you send out letters offering whatever, they won't come. And if you send out, you know, a free barbecue* [Advertisement], *they don't come, but if you go and meet them…*

Daisy: *If you go to the pub with someone from the community…*

James*: Having men's nights at the pub, you know, you get a packed house.*

Daisy: *That's worked famously. So going with the intent of sharing whatever it is that the community is wanting to share. And talking to the community about what it is that they need ... Taking a group of professionals that can do that follow on work as part of the process, has been creative, invaluable*.

The natural disaster event of the Gippsland Black Saturday bushfires in 2009, created unique opportunities for practitioners to move beyond traditional approaches to health care. Consistent with my literature review, rural farming males are known to be difficult to engage in health services because of their attitude of independence and understandings of their own masculinity (Alston, 2012b). The agency Anna, James and Daisy worked for actively encouraged them to develop alternative approaches to supporting fire ravaged communities. They, and others within this agency were valued for their skills, sense of hope and enduring commitment to supporting rural communities as local practitioners. This unwavering support fostered the development of a flexibility in engaging and working with clients for Gippsland practitioners.

Inspiration for how to support local farmers also came from a non-traditional source; an untrained male counsellor. Creative and flexible non-traditional approaches to health care emerged from a catastrophic event because of the foundational support of a Gippsland social justice agency. New practices were created out of necessity in dealing with the practicalities of rural life following a natural disaster. The land and livestock required attention despite the vortex of trauma that continued to surround faming families affected by these fires. Fences needed mending, cattle feed, or in more unfortunate circumstances slaughtered if they were too injured to survive. Rurality can once again be understood as relational. In this instance, as a

geographical rationality. That is, farming families have a deeply personal and practical relationship to their land; it's their lifestyle and livelihood. Rural practitioners who respect and acknowledge this connection are able to connect with rural families firstly as people, before offering counselling or therapy support to them. Which in turn, is more likely to be accepted by them because of the context in which it is offered. These new practices are of significance to other rural practitioners seeking to engage rural males in alternative approaches to health care.

6.3.3 Sustaining professional therapy practices

Daisy and I discuss together practice stories which inspire us as rural family therapists. James has briefly mentioned in a previous story that Daisy has a phone call recording which she keeps replaying. This phone seems important to Daisy as she has kept it. My attention as a family therapist and researcher is drawn to Daisy's story, because of emotionality in both James and Daisy as this was discussed previously. There is a gentle strength in James's voice as he makes his comments. I sense a connection from Daisy's eye contact with him that there is something of significance in this story. My practice experience in narrative therapy, has heightened my awareness for any emergence of stories which sustain people, and I suspect Daisy's story may be one of these. Another story was being discussed at the time which I did not want to interrupt, so I now return to James's previous comment:

> Annette: *I'm dying of curiosity, I want to know about the phone call*.
> Groups all laughs together.
>
> James: *Oops*! (Meaning he said this in passing in conversation, not sure Daisy wants this included in our current conversation).
>
> Annette: *You don't have to say if you don't want to* (Said to Daisy and James).
>
> Daisy: (Quickly replies). *No, it's ok. Well I have my phone constantly flashes with a red light. There's a gentleman who I've been working with down in [name of a town] for quite a while. And he rang and was very aggressive and very abusive down the phone, so I let him go on and I talked about how uncomfortable I felt when he spoke to me like that but I would look into it and I would get back to him. So I actually rang back and checked what he wanted*

and it was over money that he felt hadn't gone where it should have gone. So we checked and it had actually gone in three months prior to this phone call. Anyhow he knows that I don't work on Tuesday, like my answer machine says Daisy is not in on a Tuesday. So he rang on a Tuesday and left this message. And it's a very gruff sort of voice making an apology. And a very gruff, '"Thanks for getting back to me. And, um I'm checking, because the bloody bit of paper, that one bit of paper went missing, bit [of paper] *went missing. But you know thanks for calling me back and following up on that. And ah good luck and have a good day and I'll talk to you in the future"* (Daisy copies his laugh here*) and then hangs up.*

Annette*: That's the important bit isn't it? I'll talk to you in the future*? (Asks the group).

James**:** *Yeah, yeah.*

Daisy*: And for me that fact that he says you know, all right, not too bad, you know not too bad. I'll connect with you again when I need help…*

Annette*: That's lovely isn't it?*

Daisy*: It's gorgeous.*

Annette*: I had a similar conversation when I worked at [Name of service] when trying to engage with dads… your conversation reminded me (to Daisy) of having to work very hard to engage dads, particularly with out of control teenagers. I had a similar conversation with this dad. I basically had to woo him to join us in family therapy over the phone after having seen the daughter and mother. And we had this long conversation, with some suggestions and there was this silence. And I thought I don't know what this silence means. Is it is a good thing or a bad thing? I'm not sure. Then he said, "Mmm, you're not too bad, you make sense (long pause) for a woman".*

All the group explodes in laughter at this as, recognising and identifying with this comment's relevance to us as therapists in achieving a connection with a male parent.

Anna*: He had to put in that last bit* (Laughing as says this, large smile).

Annette*: So I have that as a quote written somewhere as well, similar to Daisy. It inspires me in those moments* [When I am unsure as a therapist with fathers] *to keep going, keep trying.*

Daisy*: And part of me knows that I should go [Her recording of her phone call] because I've heard it. But when things aren't going well I will* (Said with emphasis) *just sit and go, I just need to hear him again. And then I think yapok, and off we go again.*

Annette*: and I think it's actually quite important, quite sustaining. I have bits like that. I have letters from young people I've worked with that have had pretty tragic times. And I was sure we would get there. I have those too. And it kind of reminds me, you know there is hope.*

Anna: *Yeah.*

Daisy: *Me too.*

These phone messages are a source of inspiration to Daisy and I, which we draw upon to remind us that things can go well and we can overcome difficulties in engaging with clients. Other group members, Anna and James understand and use similar methods of inspiration. This is an important part of how we sustain ourselves as rural family therapists in the face of often limited access to supervision and professional development opportunities. Jacques Derrida (1982) and I now discuss and deconstruct these practices of inspiration to understand their usefulness for other rural practitioners.

Within our interactions with clients there are moments which inspire Daisy and I. A narrative therapy framework recognises these moments as an important part of our preferred ways of being with clients. Gathering and amplifying these moments creates new narratives of identity for Daisy and I, which are then witnessed and accepted by other group members as our audience. This is consistent with narrative therapy concepts of creating alternative constructive stories, compared to problem laden stories that people can draw upon in times of need to sustain themselves

(White, 2007). Derrida (1982) explains to me that his practices of deconstruction are part of narrative therapy and useful in understanding why our inspirational practices sustain our practices. From our discussion I propose that utilising sources of inspiration within a narrative therapy framework, is a useful strategy for other isolated rural practitioners to consider to sustain themselves professionally. Sources of inspiration can be found individually and strengthened collectively, in gatherings of like-minded professional groups. This would develop new identities of preferred ways of being with clients for rural practitioners, while sustaining them professionally in regions with limited access to professional support.

Also inspired by narrative therapy (Madigan,1999) I asked my Gippsland participants to reflect on anything that was useful from our research conversations together as we concluded our research. Identifying preferred narratives of identity is a therapeutic approach intended to strengthen emerging new desired ways of being (White & Epston, 1990).

> Annette*: Any other thoughts about what we have done…either in the group, or you've read* [in transcripts] *or the DVD? What has it been like actually doing, gathering together and doing the conversations together?* (Said to group).
> James*: Mmm, trying to remember, don't know.*
>
> Daisy*: I just think that the conversations have been really good around things like, what you're not sure of. Like, when you meet someone in the street, Anna had the same sort of experience. I think that joint experience has done a lot for me in terms of context. So it's not just me being really sensitive…it seems to be a common thread…and I've enjoyed the discussions around differences in the Koori culture and the way in which we try and engage.*
>
> The group talks about another topic and then returns to this one, as we conclude our research together:
>
> Anna*: It's been really good for me…just to be able to be able to sit down and talk in this language is a pleasant change…* (Anna and Annette laugh loudly together). *It's enthusing, it provides enthusiasm to continue on ... And just discussing the rural stuff. I'm really interested in the rural stuff and the*

differences between metro and our little small country town. And to have other peoples' perspectives on scenarios and situations is helpful for me when I'm doing this sort of thing in a small town.

Daisy*: Absolutely.*

There is a communal sense in the Gippsland group of having enjoyed each other's company as we conclude our research conversations. The sharing of similar practice experiences has allowed us to be an audience to each other, affirming and strengthening our therapeutic and theoretical approaches to working with families. We recognise each other's continued commitment to socially just practices, gaining energy and enthusiasm to continue in this work from our time together.

6.4 Spirituality

In closing this chapter, I include Mark's brief but significant contribution of how he sustains himself in his professional practices. As an individual participant, rather than a focus group participant, he adds an important dimension of spirituality to understanding his family therapy practices. This is consistent with family therapy literature, such as Walsh (2009). Mark's story articulates well spiritualty's significance to his rural practice. He provides other interested rural practitioners with an example of how to conceptualise spirituality as an important component of their practice, to sustain themselves professionally.

When teaching family therapy in a rural setting, Mark is reminded and reconnected to his patron saint of animals and peace, St Francis of Assisi. Mark explains that this saint sought out rural locations to connect with his spirituality:

Mark*: He* [St Francis of Assisi] *used to go to the rural places ...to refresh his spirit ... He would be out in the countryside because that's where he felt it was easier to touch God ... He might describe spirituality as it was easier to get in touch with one's soul and one's values when free from the demands, the noise or whatever of the city…I feel more at home in the country… I think there's a spiritual element in the rural aspect too, which is easier to contact than in the city*.

6.5 Chapter summary

Participants' stories within this chapter have been presented as Foucauldian narratives of rural resistance and resistance to dominant understandings of all rurality being the same. As such, my Tasmanian participants' stories offer rural practitioners a conceptual map of how to harness collective outrage to address social justice issues without being marginalised themselves. In addition, these stories provide examples of how rural practitioners sustained themselves professionally, individually and collectively, by drawing upon alternative understandings of rurality. These alternative understandings build further conceptual layers within an ever evolving new counter-narrative of rurality as relational and contextual. The gift this new counter-narrative offers is the unique opportunity for practitioners to conceptualise rurality differently within each of our own local contexts.

My Gippsland participants' stories also reflect rural resilience and resistance, in the sharing of their stories of offering hope and commitment to families, following the Black Saturday Gippsland bushfires. We share concepts of inspirational practices and relational connections to each other as colleagues to sustain ourselves in our practices. The profound level of connection we have together is established mutually, reinforcing our socially just practices and creating a collective agreement of the importance of family therapy practices for us. Our stories further strengthen a counter-narrative of rurality as deeply relational. These understandings are important in the contribution they make to considering how rural therapists might legitimise collegial relationships to sustain ourselves within challenging rural contexts.

Chapter Seven

Dorothy's story: A journey of transformation and change

> One's always writing to bring something to life, to free life from where it's trapped, to trace lines of flight (Deleuze, 1995, p. 141).

7.1 Introduction and analysis

This chapter explores Dorothy's story of discovering and developing her rural family therapy practices. In addition, the impact of these practices for herself, her clients and their families, and her own community. Dorothy speaks of how she assimilated family therapy concepts into her rural "*community psych nurse*" practices. These concepts transformed her therapeutic work with families, and their importance is highlighted in her narrative of 'becoming' (Davies & Gannon, 2009) a rural family therapist. Dorothy then became a teacher of family therapy to metropolitan and rural students. Her narrative draws together two significant aspects of this study; rurality *and* family therapy. Dorothy's story offers the most detailed and unique discussions by my participants, of the development of family therapy training and the connectedness of rural students to each other and their communities. This adds a complexity and richness to understandings of practicing rurally, as part of an ever emerging counter-narrative of rurality as relational. To ensure we understand this story from Dorothy's perspective, and because she provides such rich extended detail, I am including long sections of the interview transcripts.

My approach to analysis continues to be a layered one. I am now joined at my dinner party by Deleuze (Deleuze, 1988, 1995; Deleuze & Guattari, 1987; Davies & Gannon, 2009; St. Pierre, 2001) to discuss Dorothy's story as being one of transformation, change and becoming; and Foucault (1980; 1982; 2000) to consider his concepts of power and resistance to highlight aspects of Dorothy's story as a resistance to traditional medical views of the limitations of her mental health practices. Derrida (1982) has remained at the table and joins us in considering deconstructing and 'disturbing' elements of Dorothy's story.

Dorothy quickly takes command of the discussion creating a lengthy narrative with her as the main author. I am positioned as her willing audience and consistent with a PAR approach, I readily take up this role. Dorothy is a natural storyteller, using hand gestures and humour to maintain my attention as she talks. Her use of expressive language is meaningful, drawing my attention during analysis to aspects of her story by her repetition and emphasise of selected words. I note these occasions of expressiveness in the following narrative, to alert readers when these happen. Dorothy's expressiveness guided me as her audience to moments important to her within her narrative of rural family therapy practice. This is consistent with a narrative dialogical/performance and visual approach to analysis (Riessman, 2008). Dorothy and I share an identity as psychiatric nurses and occasional teaching colleagues. This relationship is evident in our interview together from our eye contact, nodding and mutual understanding of each other's comments.

I wish to acknowledge and respect Dorothy's generosity in sharing her understandings of rural practices for this research study, while maintaining her own and clients' confidentiality in line with ethical considerations of family therapy practice. Rural family therapy practice often raises intricate ethical issues in small communities where we, as therapists and people may be known to many (Zur, 2006). Therefore names of rural towns, family therapy training centres, city names and names of family therapy trainers Dorothy discusses have been removed and replaced with generic prompts for readers.

7.2 Dorothy finding family therapy

Dorothy and I make ourselves comfortable in her family therapy practice location. We each sit on a chair facing each other. I have set up the video camera to record this session and explain the research questions again to Dorothy as we start to talk together. Engagement processes are important to us as family therapists, and I have transferred these into my research conversations with participants.

> Annette: *Its rural family therapy that I'm interested in. Particularly any ideas you have about your own practice or ideas that you've seen. Particularly*

because you've been teaching also rurally a little while as well as teaching here [Metropolitan family therapy training centre name].

Dorothy: *Well I guess I was working in the rural, rural not remote, Australia* [Dorothy clarifies her context here as rural, not remote Victoria. This is consistent with Australian classification systems outlined in my literature review] *when I, when I came upon family therapy. I was working with families where there was mainly a symptomology of schizophrenia. And as a community psych* [psychiatric] *nurse my treatment modality was to drive around to peoples dairy's and give their adolescents sons or their adult sons with paranoid schizophrenia modecate injections. And then take their blood pressure and that would be it for a fortnight. That would be the therapy that they would get. And um, or if they were becoming unwell then I'd go and organise for them to be in hospital so there was, there was*…

Dorothy pauses for three seconds while thinking. Looks at Annette.

And it used to be around the kitchen table or out in the dairy you know. Like," Pants down and here's your shot". And I got that they were incredibly isolated because those people become isolated from community and from extended family. And that they [her clients] *were treated in a sort of infantilised way by…*

Dorothy pauses for second pause while thinking

Dorothy: *By their family. But also that they were treated in a way that they were forever going to be sick like unwell. So I didn't think that. I didn't believe schizophrenia had to be a permanent thing. I believed that it could be something that could be transient. People dip in and out of psychosis um …*

Dorothy waves her hands to indicate an in and out motion.

Dorothy: *In order to cope with their, their real life. That it's a coping mechanism and that they would and so, what my experience was is that once someone developed the symptomology, is that the families would then collude with those symptoms. And they would enact, or that they would facilitate the psychosis or the anorexia or the bipolar disorder or whatever it was. And I, so I thought there must be something that you could do with families* [to help

them]. *I'd never heard of family therapy, and then I heard of family therapy and so I started training in [name of city]. And I was travelling, I was travelling about six hours a day to come up and do my training so that was fairly* …

Annette: *Where were you travelling from*?

Dorothy: *From* (name of her own rural town).

Annette: *Ok, that's a hike* [long way].

A deconstruction or 'disturbing' (Derrida, 1982) of Dorothy's narrative reveals her position within a contextual history as a psychiatric nurse working with family members experiencing schizophrenic disorders. As such, her treatment as a "*psych nurse*" at this time was informed by her prior training, which was in turn itself based upon a medical model of understanding health and illness. Mental illness within this model was predominantly viewed as requiring medical treatment to achieve wellness, primarily with medication and hospitalisation (historically called institutionalisation) to contain and control symptoms of psychosis (Chesters, 2005; Laungani, 2002; MacKinnon & Coleborne, 2003). This became, in a Foucauldian (1980) sense, the dominant narrative of mental illness as an individual issue, requiring medical treatment.

Dorothy's story of her past nursing practice being guided by a medical model fits with the history of the treatment of mental illness in westernised countries, such as Australia and New Zealand (Coleborne & MacKinnon, 2006; Warelow & Edward, 2007). A client's care was (and to a large extent still is) supervised by a medical practitioner, usually a psychiatrist, who had the authority to mandate treatment with or without a client's consent (Coleborne and Mackinnon, 2006; Victorian Government, 1986). The dominant narrative of the medical treatment of mental illness remains a powerful one currently. Historically the involvement and acknowledgement of the importance of family members in a client's treatment, where clients consent to this, has not always been part of mental health treatment (Pickens, 1998). It is only in more recent times that families have advocated for and gained recognition of the importance of their role in the care of other family members (Lammers & Happell, 2004) to begin creating their own new counter-narratives of

treating mental illness. This history of medically dominated narratives of mental illnesses is important to family therapists and mental health professionals interested in countering these understandings. Conceptualising new narratives of mental illness as a systemic family and community issue, to facilitate recovery and reduce stigma, requires us to understand the issues of power and resistance (Foucault, 1980) involved in their creation. Narrative therapy, which utilises these Foucaudian concepts, provides family therapists with a theoretical framework to guide the development of preferred narratives of mental illness with our clients.

> Dorothy: *Yeah so I used to work around* [name of her own rural location] *and places like that as a community psych nurse. And so I would come up and I was pretty stunned with* (Two second pause while she thinks) *ah the usefulness of family therapy and I guess every time I would come back* from [training venue] *I would come back with a new, a new theoretical framework*

Dorothy becomes begins to move her hands while talking, becoming more animated and excited in this section of her discussion.

> *Dorothy: And you know we would all be doing family of origin one week and then we would all be doing strategic and then we'd all be doing structural and it* (Two second pause while thinking). *I started seeing results actually quite quickly. And it actually changed,* (underlined words said with emphasis) *me knowing family therapy. It changed how I was in the system as well. It changed me colluding with ah the um* (Three second pause while thinking) *the externalised symptoms to use a Michael White* [a co-founder of narrative therapy] *word, externalisation. So that actually helped me to think about things differently, internally and externally and put it in a sort of different construct I guess. And then I talked to families about you know how they could be different and how not to facilitate things. And so it was almost like, before I started doing family therapy with them. It was almost like I was taught* [how to] *teach families family therapy frameworks. Like theories like, talking to them about structural um or structural considerations that they needed to put in [their interactions within their family]. That the child was not sort of elevated to the parental hierarchy and so forth. And that the um the sibling ship um was you know the subsystem was kept close and connected. And so I would talk*

to families about this rather than actually do the therapy around it. Because often I would be, it would be whilst I was [sic].*At that stage I still didn't have the um luxury of you know, of doing much therapy other than you know. I had thirteen people to see in a day. I had to see them and so it would often be a discussion around the dairy or around the kitchen table while I had a cup tea and went to the toilet. And [I] talked to the families about these things and give them some articles on family therapy. And so that was interesting as they became almost part of the journey with me. And then as we contained, and they built up some faith and hope that there could be difference, then I would move some clients around ...*

Dorothy moves her hands to represent this moving of her clients.

Dorothy: A*nd maybe instead of seeing everybody you know, the thirteen people on a Tuesday, then I saw six one week and the others six the following week. So it gave me time to actually start doing some therapy with the families. And so it would be in their homes. It was always you know in their homes or in their machinery shed or wherever they may be. And it was quite lovely. One of the problems with it was that often it was difficult for me to move from a medical to a systemic model. And I think as a psych nurse I battled with that for a long time. But of course the battle that I was having that I had internalised was of course the battle that the clients were having and the families were having. Anyway I started to see some changes and instead of going, this sounds a bit ...*

Dorothy pauses for two seconds while she thinks.

Dorothy*: This sounds a bit fanciful but it's actually* <u>*true*</u> (underlined word emphasized). *That instead of actually going to peoples funerals I stared going to peoples weddings. You know, adolescents, that young people with schizophrenia because I'd worked in that community for a long time and I went to lots of funerals of people who suicided um* (3 pause looks thoughtful). <u>*But*</u> *(said with emphasis) it started that I would actually be going to their weddings (looks at me and smiles). And that these kids would get through year twelve [at school] and so on. Because we or I would be working more*

systemically with the family and it was um quite amazing. And um and even now when I, because my dad lives down in that area, and when I go there it's just really wonderful. And so it was a very useful practice given that I was working in...

Dorothy pauses for three seconds while thinks of her next words.

Dorothy: *In acute psy*-[psychiatry] *acute and um chronic um psychiatry. It took some effort to get any footing with my colleagues, because there's a safety if you're a practitioner. If you work in the medical model because um the safety is that you remain detached from the family and that you can, well that's how it seemed to me, that you remained detached from the family. But you also* (Three second pause then gives a deep sigh) *there was less effort on yourself. You know there was less of you in the outcome. Um so it* [family therapy] *wouldn't get a lot of sort of credibility. Certainly it would now because I'm talking about twenty years ago. So that was lovely and then after I'd finished that and I was still working in that area, I was invited to teach in* [name of town] *in their campus in rural family therapy training .*

A Foucauldian (1980) understanding of power and resistance unearths Dorothy's resistance towards the then dominant narrative of mental illness as an individual issue, requiring medical treatment. Her resistance leads her to take up family therapy practices which facilitated alternative understandings of mental illness as a systemic issue for clients and their families. Mental illness was conceptualised differently, and this new understanding shared with families themselves to offer them insight into managing the impact of these illnesses upon their lives. A new narrative of mental illness as a systemic issue was created to counter the dominant narrative of mental illness as an individual illness. This new counter-narrative shifted power away from medical colleagues back to clients and families, in the management of their own mental illnesses. It also creating further resistance, by these families themselves to the dominant narrative of mental illness within their communities. In addition, change occurred not only in clients and their families, but also within Dorothy herself as a practitioner as she embraced family therapy practices of systemic thinking. Dorothy's story emphasises the importance of systemic thinking that includes the family therapist as part of the system. Systemic thinking creates new ways to not only

understand the wider systems our clients and families are part of, but also the important role we play in these systems ourselves.

7.3 Growing family therapy and rural connectedness

Dorothy: *When I started working for psych* [iatric] *services a long time ago, and I did my psych* [iatric] *nurse training. I remember you know, it was a time of schizophrenigenic mothers and absent fathers and so* …

Annette: *I remember those times* (We smile at each other recognising our shared histories and understandings as "psych nurses").

Dorothy: *Yeah, and we would have a policy of not having anything to do with parents when we were seeing adolescents. Because we would invest all the evil in the parents. And of course the adolescents would just get madder. And whilst there may have been some family life changes going on, and they needed to have some separation or differentiation all we did was cut them off. And they would just go mad and unfortunately kill themselves. Not all the time but sometimes. And so it's been really nice to be able to see that change. And I guess also in rural Victoria, rural areas if someone has a go at trying to kill themselves it's usually with a gun* …

Dorothy emphasises her words when she says "*with a gun*".

Dorothy: *It's something really savage so you don't get many goes. Like you don't get a little bit of a warning so you can actually then come in and do those things* [to help]. *It's usually sort of over pretty quickly. Um so it's been really useful,-it's been lovely to see that change. I was looking at um, I was lecturing students on suicide the other day. And I had just gone through some statistics of what the suicide rates are in Australia at the moment metropolitan versus country. And I noticed that there was a drop in, in adolescent rates.*

Annette: *Rurally*?

Dorothy: *Rurally, and I wondered if things like family therapy had contributed to that in any way or maybe actually farmers lock their guns away now I mean* (laughs).

Annette: *I actually have the new stats* [statistics] *as part of doing Mental Health First Aid* [trainer] *updates. Part of that is, that the reporting hasn't been done that well .And they have actually picked up quite a few that have been missed in the past. So yeah particularly Indigenous people's rates have been underreported. Lots of peoples deaths aren't picked up as all* [Australian] *states don't collect them consistently. Also the other things is that rural* [suicide rates] *has dropped. But remote* [rates] *are still climbing for younger males*.

Dorothy: *Yeah, they still don't have the agency support out there do they*?

Annette: *Yeah, so it's almost like the main stream, because this used to be my bread and butter in my other job* [suicide prevention]. *The mainstream sort of strategies for youth suicide I think have maybe hit the masses. But the people who are on the fringes particularly the isolated and particularly our Indigenous adolescents, and um anyone that is sort of marginalised, they are really struggling. Which is interesting that their rates still climb. Yeah it's interesting the whole notion of how they do* [collect] t*he suicide rates is quite political. I wasn't aware of that until I started reading the data.*

Dorothy: *I need to have another look at that*.

Annette: *If I remember I will actually email you it because we get the updates*.

Dorothy: *Ok, That would be good.*

Annette: *I get the graphs and things you show to people* [educational materials].*They* [suicide rates] *are spread out over age groups. It's interesting when you pull it out and can see it over a couple of decades. So you have the First World War, the 1960s, 1990's with the economic stuff happening with higher rates. And whenever there's a war the rates drop.*

Dorothy: *Yeah that externalised enemy. Yeah that would be good. So yeah, it has been useful to look at that.*

Dorothy identifies a strong link between mental illness and suicide from her previous "*psych nurse*" practices. Early identification of the risk of suicide within families

affected by mental illness, continues to be an important part of suicide prevention strategies for current mental health practitioners (Australian Bureau of Statistics [ABS], 2010, 2012a; Bagarozzi, 1982; Beautrais et al., 1996).

> Dorothy: ... *So most of the trainees that we would have would come from rural and remote areas. And they would come for a Friday and Saturday and stay the night in* [name of town where they trained, M]. *You know some people would come from* [name of three towns on border of Victorian and New South Wales border] *or wherever. And one of the really nice things about that, as opposed to the city training, because I would be training almost simultaneously* [urban and rural students at the same time]. *I would be training rural students and training metropolitan students, and one of the really nice things about you know working and training the rural students is that they would get it really quickly, they would get systemic stuff really, really quickly. And because they were incredibly isolated from each other this meant that they would start developing a network. Because if they um, would go back to say ...*

Dorothy pauses very briefly then names a small town

> Dorothy*: And they would be the only family therapist, they would feel an enormous pressure not to work systemically. Many family therapists, whether they've trained rurally or metropolitan in the metropolitan area, I think that after about five years of training they stop doing systems work. And they go back to the, if they're not working in an agency where it's given a lot of credibility, that they go back to actually working in the medical model because it's easier to actually collude with the dominant treatment modality, rather than actually push the other. So what working in [name of town] did is that it meant that there was a network of rural family therapists who could actually ring each other. And now with email it's been it's been much better. And it would start the infiltration into these different places and they would lend books and I would give those journals, journal articles just to leave in the agency somewhere in the tea room. So that we started like this infiltration process in Victoria. And I would say, I don't know how many people we would have trained now in* [town M] but *it's a couple of hundred, like several hundred.*

Annette: *Because you're been going awhile. How long have you been going? It's quite a few years isn't it?*

Dorothy: Y*eah. So we've been going long enough now, that the people that we started training now supervise the people* [we train currently]. *Because they have been clinical VAFT [Victorian Association of Family Therapists] members for over five years. So that's been really lovely. So* [town M], *as a community though it's not really rural, it's like a rural city. But places like [small town geographically distant from her] and so on, are now having a lot more family therapists. And now as those numbers have increased then there's more permission giving for agencies to allow their staff to come and do family therapy training, so it's been wonderful. It's been absolutely wonderful. So that is the differences in the students. What are the differences*?

Dorothy pauses for three seconds while she asks herself this question, and ponders her answer. The pause continues for another five seconds, while she thinks.

Dorothy: *Um, there's <u>an ease</u> (Said with emphasis) amongst the students. That there's a comfort amongst the students that they're not competing academically with each other. I would note that at* [training center name] *that we actually don't just pass or fail people. They are not scored and I think that works really well for rural people. Because they might come from a welfare background, and someone might come from a senior social worker* [background] *or a someone might be a psychiatrist. But they're actually all doing the training at the same level. So that they can actually work at their* [own] *level and they're not competing with each other academically. They are improving their family therapy skills and taking them* back [to their own locations]*.It's really lovely, say in* [town M] *there's a couple of psychiatrists that have got family therapy training and who have been part of our training, our family therapy training program. They are working with, or that they know of other people who are working in direct care and so on. And there's a common language* [of family therapy] *that I think is really really very useful. So now when there are things like referral letters or handovers, um people will talk about the family or the genogram so that that um rather than just an*

information collecting tool it's um, it's a therapeutic tool. So those changes have been really lovely to see. And I think um ...

Dorothy ponders again, her face an expression of concentration.

Dorothy: *Yeah I think that that there's, that how we teach in* [town M] *actually respects some of the difficulties that are there too. So that if you* [are] *working with a family, that you wouldn't necessarily have just the family of creation or family of origin, you actually might have the neighbors come in. And so, you would look more at the extended community and include them in the therapy. And I'm particularly um referencing Michael White again, but looking at those outsider witnesses* [practices within narrative therapy*]. So that you would, um, yeah, you would have more direct interaction as a family therapist with outsider witnesses that weren't necessarily other agent-service providers. So they wouldn't necessarily come from DHS* [Department of Human services]. *They could be Mary and John* [fictitious names] *from the farm down the road. And that they would come along and support those changes that are going on for a family that was in strife. So that's been, that's been really lovely.*

Annette: A*nd that's probably, that's going to continue for some time* [training in family therapy]*, because it's going well?*

Dorothy: [Town M], *the* [town M]*. Yeah I think it will, I think um* (Four second pause while thinks). *Yeah I think it will. Every now and then we look at doing something in* [another town] or *whatever. Yeah I think it will go well. It's interesting that we've had people come down from [name of out of state town] to, to study in* [town M]. *And* [this out of state town] *is a bit like a big country town, and it saddens me that they don't have access to training facilities there. That it's really just down the east coast that there's training facilities. So we need to actually need to think about that about more as well. And I think what's nice too, that there is now, I go and run workshops in you know* [name of two small towns] *or whatever. And that now rurally trained family therapists, certainly the ones I know feel more competent and...*

Dorothy is half way through her interview and completely engaged in her story.

Dorothy: *That they feel some some keenness (Said with emphasis) to spread the word a bit, to prophesize* (Laughs) *about family therapy*. *And I think that's really lovely that they have been able to do that. And that there is enough confidence in the work that they do, to be able to do that. And I would say, probably about 10 years ago, I thought that the respect for family therapy anywhere was actually diminishing. And I thought it was sort of running down and I think that had a bit to do with you know some of the, some of the passing of some of the big names. And it will be interesting to see now that, you know Deshazer, Insoo Kim Berg and Michael White, Peggy Papp,*[famous family therapists] *etc. that they have all died, if it* [family therapy] *will be regenerated and that there will be like a next generation. I hope that there will be more. I certainly hope there will. But I actually see now when I'm looking at you know websites, or you know for jobs and so on, I see now that a lot more rural um, health service agencies will put family therapy in there as well. That's fantastic and you know when I started doing family therapy you would never...*

Dorothy says never with firm emphasis.

Dorothy*: See a job that would advertise for a family therapist. Not in rural Victoria, you might in the metropolitan area. But so that's been really lovely I think And there's been quite a few people who, well in fact some of them I supervise down in DHS in [town M] ,who are family therapists and I just think it changes the whole nature of the agency. Because they, the blaming goes and that they can actually see things longitudinally. That they take more into account the family of origin and don't get frustrated with the sometimes, the minuteness of change. That there is more patience knowing that it's a longitudinal systemic change that needs to occur rather than the quick fix.*

Dorothy clicks her fingers quickly three times to emphasis her words "*quick fix*".

Dorothy: *I think that's working better and I think also that it has been important for rural communities ... And I think again that's one of the nice things about being able to train therapists rurally is that, I talk to people as I'm talking to you now. That it's pretty chatty and yarny. And there's an easier way of*

learning. That it's sort of an engaging conversational way of learning, rather than sitting up with the power [point] *presentations and so on. And so that's really lovely then that the students can take that back to their community. Because I would argue that how we teach family therapy reflects how family therapy should be carried out with families. So if I, if I hide behind you know a power point presentation and I don't make myself available and I don't engage with the students that are there, I can't expect them to do any more than that when they're working with families. So I think that we are more mindful of that when we're are teaching rural folk.* (Four second pause while thinks).*Yeah, yeah it feels easier. The teaching between* [town M] *and* [name of city], *it's interesting that if you were a fly on the wall you might think that what we do in* [town M] *doesn't look very professional*…

Annette: *Oh ok.*

Dorothy: *But because there's a bit of a different structure and the numbers, the rural numbers that we teach usually are smaller too, so it makes for more intimate and more connectedness. And teaching the group process is much better but I think. I know that we turn out better family therapists in our rural campus than we do in our metropolitan campus. I'd say that and* [teaching colleague] *would say that. And anybody who's taught in both* [metropolitan and rural locations] *would actually say that that our rural students actually get it much quicker* (clicks her fingers three times to indicate this quickness)*. That's a little about the format I think of the teaching because we have the two day blocks. They need to they work very quickly. So we do their genograms and things really really quickly. And they, they already come with a willingness to connect, that rural sort of engagement thing. And the structure of the training actually facilitates it as well. But I think that our family therapists that we turn out down there, are actually better than the ones we turn out here but I'm not quite sure that I'd want to say that to our* [city name] *students.*

Annette: *I was interested when you talked about that connectedness. Can I just pick up on that*?

Dorothy: *Sure*.

Annette: For *a moment because you talked about that connectedness between the rural students can you say a little bit more about that?*

Dorothy: Um.

Annette: *What do you mean by that?*

Dorothy: *Ah well there is something about, if you're one of few that you need to keep the interpersonal connectedness going more so that you're supported. And I think that connectedness actually reflects what it is that we are trying to do in families anyway. And so the fact that they* [Dorothy's students] *can have that connectedness and they can experience it quite well and we facilitate it too, we really facilitate group process. I spend a lot of time doing that, but if that connectedness is there and they then learn that experientially, they are much better at actually helping the family do the connectedness. So I think that they have a greater capacity, I mean I would argue that that there's a couple of things about family therapy that work really well, and one is the conversations that you have, the nature of the conversations, the nature of the questions and the nature of the answers and the information sharing. But the other one is actually without even saying anything, is actually the promotion of relational connectedness. Yeah and working out what goes on in this space between. I reckon the rural students are better at this connectedness and the engagement with the family than are our* [city] *students. And I think it's about where they come from. I think that rural people actually have to do that* [connection] *or otherwise they're out in the cold. It's a bit like you know Schopenhauer's porcupines, you bloody die if you're out in the cold. So there has to be some sort of dance of connectedness there. But I think it's also that our teaching reflects a more rural view. Yeah I think that they are really good at connecting with families really quickly. I'm often really struck that they sort of just get in there. They just slide in underneath there mmm, and that's quite lovely.*

[Schopenhauer's porcupines, whom Dorothy refers to in her story are those of philosopher Arthur Schopenhauer (1788-1860), familiar to many family therapists. He uses a metaphor of porcupines trying to get close to each other to illustrate the

dilemmas of achieving human intimacy. Luepnitz (2003, p 2).depicts these dilemmas well in her version of this metaphor:

> A troop of porcupines is milling about on a cold winter's day. In order to keep from freezing, the animals move closer together. Just as they are close enough to huddle, however, they start to poke each other with their quills. In order to stop the pain, they spread out, losing the advantage of co-mingling, and again begin to shiver. This send them back in search of each other, and the cycle repeats as they struggle to find a comfortable distance between entanglement and freezing.

Annette: *And it's lovely how you describe it because it actually sounds as though you have really tailored and made the training. You've taken the training to really suit rural as well?*

Dorothy: *I think, it's been a little accidental. I think that there has been the desire to tailor it to the rural community. But I think it's probably evolved with less deliberation. That the people, the participants, actually helped to create how the therapy is taught as much as anything else, does that make sense?*

Annette: That makes sense to me completely. I'm thinking about similar for us working [in own family therapy training Centre] *too. And even doing the tutorial groups. I do further east* [region]. *The students do as you say. My stepping back and outside facilitation allows them to create facilitation processes themselves.*

Dorothy: *That's right.*

Annette: *They just do it*,

Dorothy: That's right.

Annette: *And when you allow them to do it they do it very well.*

Dorothy: *Yeah which is the same, it's the sort of template. That if we are working with families that we need to actually adapt to their way of being and thinking rather than converting them. So I think that given that we do that in the training, it again facilitates the students being able to, um readily um adopt*

and adapt to what's going on with the family um (Four second pause while thinks). *Yeah it is quite different. There's more humour too you know, like sometimes it's fairly black amongst the rural students. And they don't take themselves as seriously, with some of the issues. The issues they would be working with would be no, no well they are different but they are no less tragic than their metropolitan counterparts. But* (Laughs) *you know they have a little bit more of an attitude that life goes on so they don't take themselves too seriously. So they tend to take their training and their work, I think a little bit more in their stride. And that there's less sort of oh,* "*Oh my God".*

Dorothy takes a big breath in illustrate her students stress and reactions to it.

Dorothy: *There's sort of, "Well ok let's see how we can sort this out and work through these things". And I think that taking a <u>not</u> (emphasizes this word while speaking it) "Oh my God", attitude to families actually really helps to normalise things for families and settle them. And then of course they can start to actually re engage because of course the family sort of "Oh"* (Dorothy again takes a long breath in to illustrates a family members reaction to students stress reaction) *you know disintegrates doesn't it?* [Engagement with therapist]. *But if the therapist can actually settle and calm* [the family] *they can regroup and support each other again. And I think that rural people doing that really quite, quite delightfully.*

Annette: *Good I'm also keeping an eye on time for you, because you have someone coming at five pm, in five minutes?*

Dorothy: *And what else should we cover?* (We laugh together at how much we have already talked about, and the depth of our conversation).

Annette: *Well I've got world peace left (we again laugh together in recognition of our mutual understanding of how important family therapy is to us both). I think that's, no it's going to take me a bit to think about that. It's actually lovely a lot of the things that you have said. My mind is kind of thinking and making connections. I'm just delighted that another group of rural um students, rural practitioners who are connected like that. Because that's not what I have got in other places* [while teaching]. *They* [the students] *are feeling still very very*

isolated and wanting to connect. But finding it really difficult and even, particularly in our region, after all the years of doing training. They are just so stretched over such a big area that even when a few of them get together, there hasn't been enough of a, of nucleus to form a body to keep the momentum.

Dorothy: *Oh, ok right.*

Annette: *Which is really sad. It's only been recently that we have been able to start getting clinical members because there have been so few people to be the other supervisor and referee. It's been really working hard with students to do that and promote it. And there's certainly the interstate interest* [in family therapy training], *I agree with you. There's certainly the interest. And people talk about the um, absolute thirst for knowledge too. You know, that they are like sponges* [rural students], *you know dying to have the ideas but finding it really difficult. And* [another rural teaching colleague*] was talking about that up her way as well. That it's been a little bit like that since her training has finished. Seems to me in talking to people, there's a connection between if the* [family therapy] *training is happening there's something that generates, you know like an ongoing motivation or interest. There something about having training that actually helps contribute towards people pulling together and developing networks.*

Dorothy: *I agree and I guess that's true of all sorts of institutions isn't it? So I think that's understandable and I guess that you also need to get a critical mass of students. And I think that probably we have been able to do that in the western district and I don't know if you know about how that happened?* (Directs this question to me, with enquiring look).

Annette: *No* (Said in an interested tone).

Dorothy: There's *a psychiatrist, well unfortunately now [his name N as pseudonym] has died. He died some years ago. He was just the loveliest person you could come across really. I'm sure not everybody in the world felt that and he um he worked out of* [her training center] *and he co-wrote some of*

*the book or at least one book with [*colleague]. *And he was ...one of the forefathers in Victoria or in Australia* [of family therapy]. *He knows ...*

Dorothy is much further along in her interview and pauses familiarly for three seconds while she thinks.

Dorothy: He *knew* [name of two colleagues well known and respected in Victorian family therapy community] *all the local suspects around* [city name]. *And he became the psychiatrist superintendent of* [name of institution], *which services a huge rural area. And he decided that he was going to have family therapists train in [local town] and it was* [at] *his instigation ...that we did... So we would have all these wonderful clients would come and he would give an enormous amount of his time. And then some of his psychiatrist friends were trained in family therapy and the current psych super in* [name of same local town] *now has done a little bit of training and is in talks with* [training colleague] *about that. And they have facilitated the training. He had the dream that if there was a critical mass of family therapists it would actually change the community. And I think there are changes occurring ... That sort of isolation that rural family therapists can experience ...That sort of came to an end with him. Because there were all sorts of people who had this* [family therapy] *knowledge. So it was a huge gift to the* [location in Victoria]. *It's a huge legacy, really huge legacy. So that is pretty much how that started. Yeah it was quite big really. So there's been lots of people, it would be interesting for us to go through the number of people and see how many family therapist there are who have been trained like that … And yeah as you know, I've done a bit of training in Tasmania and you know I've noticed the difference there, with those students too. That they can come together and be more collegiate more quickly and oh* (Three second pause while thinks). *I think that just actually helps and if you feel supported in your training then you will feel, feel more um supported and able to do the work that you need to do.*

Annette: *Yeah they* [Tasmanian students] *feel really connected and they have sort of formed a small mass.*

A history of rural family therapy training is described by Dorothy which highlights qualities and attitudes of rural students as being more connected to each other and their clients, than their metropolitan counterparts. Rurality creates a context within which relationships matter because of the size and intimacy of small community settings. Students training in family therapy draw together to support each other as colleagues to counter professional and geographical isolation. In addition, this connectedness is an experiential resource which can be drawn upon during training for students to understand first hand concepts utilised within therapy with clients.

7.4 “Gossamer threads of connection”

Dorothy: ...*I think that rural people have more of the ability to connect with and want to assist their fellow human being um whereas I think that they, I find that the metropolitan students will be saying to me where will this lead, what jobs can I do and what money can you make out of it and so that’s a little bit of a difference too; that something about the charitable nature of rural people anyway I think um, and that’s important* ...

Annette: *That’s interesting because that hasn’t come up before, yeah I’m actually fascinated I was thinking in my head when you were talking, that systemic stuff was really interesting. That’s been a comment that has reverberated through a number of interviews about rural people tending to be more some say naturally systemic but picking up the systemic that’s interesting, that’s been a theme.*

Dorothy*: I’m from a small country town myself um but I have lived as long in the city as I have in rural Victoria, um they’re [her rural students] not competitive with each other, you know. They are not so, they are more sort of, they come to families in a position of grace almost. And that their, their language doesn’t get, um doesn’t get all confused and I get worried if I’m supervising someone who is ...*

Dorothy laughs loudly.

Dorothy: *Is using all the jargon you know and doesn’t get to actually use the language of the family. But I find that rural family therapists actually are very*

good at actually just talking on the family's level rather than expecting the family to be able to have the knowledge to talk on their level. And it's something I'm constantly telling people, just you know just down there just [to] *be with the families. That's something I've noticed that rural people, rural folk do well is that they can be at the same the same level and that they don't take, they don't steal the authority away from the family ... They more effectively keep the family as the expert. And I remember a long time ago again working in rural Victoria when a family therapist used to come down from* [city name], *they used to come from* [city family therapy centre] *and that was when I sort of got to know about family therapy, and without naming names, that they would come down, they would do all these wonderful things and I would think they were fantastic. But the family had no bloody idea what was going on <u>and, no idea</u>* (Underlined words said with emphasis*).*

Annette (I say this at same time Dorothy does) *What was going on?*

Dorothy: (Laughs) *Absolutely no idea and so it's then they'd get in their cars and go back to* [city name] *and write their reports and it would be sort of like <u>yeah.</u> And it was I mean it was it at least some gesture* [that this therapist visited rural families] *but it was a token gesture. But the language was such that, that the therapy was not accessible to rural folk. ... And I think also that I have this concept of you know, I talk about what keeps people attached to the planet is the gossamer threads of relationship. And, and I think what we have now is a group of family therapists in some parts of rural Victoria that is you know, like the saying that we have, that we need those gossamer threads of relationship to keep families going. And to keep adolescents attached and so forth and keep the suicide rate down. The gossamer threads of relationship have actually perpetuated a larger system. And so the larger system now holds, holds families in a different way. It's in a more nurturing, rather than critical way. And I think that has made a really big difference. Even if there's not family therapy practice <u>going on.</u>*

Dorothy says the underlined words with emphasis.

> Dorothy: *That the mind shift in some of the practitioners who have made- a systemic mind shift,* [moved to think systemically] *rather than symptom based or medical based mind shift. It has changed their interactions and their holding of people and I think that's a really big difference um* (Three second pause while thinking).*Yeah I mean I, that's just anecdotal. Like I guess that there's no research been done around that that. But I, but it would appear from the people I am supervising* [in family therapy] *who work in rural Victoria that's what is going on.*

Dorothy's story explains well how employing family therapy's systemic thinking practices creates opportunities for practitioners to understand rural communities as unique structural arrangements. And further, to explore the rural connectedness between our clients, their families, our professional colleagues and ourselves within these structures. The intimacy of small rural communities requires family therapists to be deeply connected to our clients and each other, while maintaining our therapeutic practices. 'Gossamer threads of relationships' allow rural family therapists to therapeutically hold our clients, while fostering professional networks with each other to support and sustain ourselves professionally. A 'critical mass' of rural family therapists is required to strengthen these networks and ensure their continued development. These understandings of rural connectedness within Dorothy's story contribute significantly to the ever evolving new counter-narrative of rurality.as relational within my analysis.

7.5 Dorothy: Transformation, change and 'becoming'

A further deconstruction (Derrida, 1982) of Dorothy's story suggests that it begins and ends with her discussion of taking up family therapy practices and principles in the face of a medically dominated health system. Dorothy proposes that this health system has changed over time, moving more recently towards an acceptance of systemic family therapy practices. Family therapy becomes included rather than excluded in the medical practices and training of psychiatrists, who primarily direct clients' care. This inclusiveness of family therapy practices within medical professions fits with the historical development of family therapy itself. Family therapy developed initially from psychiatry (Broderick & Schrader, 1981) as professionals began to question how families were involved in a patient's psychiatric

illness. Practitioners moved away from the then standard practice of focussing only on an individual patient's treatment. They began to consider their patients as part of wider systems, such as families. This contributed to the beginnings of systemic thinking practices, a distinctive feature of family therapy. This historical view of the development of systemic practices is relevant for current rural family therapists seeking to maintain these practices in their therapeutic work with families. In a Foucauldian (Neal, 2009) understanding, practices change over time despite often being presented as a fixed reality of the time. Systemic family therapy practices have gained acceptance within medical paradigms of treatment more recently, demonstrating a movement in peoples' perceptions over time. An awareness of the transitory nature of our realities allows practitioners to gain a longitudinal perspective of the acceptance of our family therapy practices. What is not accepted now, may be in the future, and vice versa. This is a useful attitude for practitioners in maintaining patience while awaiting further acceptance of the values of our systemic family therapy practices for clients and communities. This is also consistent with social constructionist theories which understands individuals as being embedded within wider historical and sociopolitical contexts (Burr, 2003; Gergen & Gergen, 2008a, 2008b).

Dorothy's story illustrates her own professional journey of transformation and change as a family therapist and teacher of family therapy. When considered within a traditional medical model understanding of mental illness as an individual concern, Dorothy's practices could be understood as a failure to adequately address issues of illness management and suicide. These understandings are consistent with a dominant narrative of mental illness as a primarily a medical concern, requiring medication and hospitalisation. Alternatively, my further analysis of these same practices, understands Dorothy's story as a counter-narrative of resistance, in a Foucauldian sense, to medically dominant treatments which were not useful for her clients and families in dealing with mental illnesses.

A further alternative understanding of Dorothy's story is one of becoming, informed by the work of Deleuze (Deleuze, 1988, 1995; Deleuze & Guattari, 1987; Davies, 2004; Davies & Gannon, 2009; St. Pierre, 2001). Durie (2009) proposes that French philosopher Gilles Deleuze was "more of a thinker of *becoming* than of being …

[and] becoming is, for Deleuze, first and foremost *creative* "(Durie, 2009, p. 126-127). For Davies and Gannon (2009, p. 20), Deleuze's work, "is intended to unsettle old ways of thinking", while a Deleuzian concept of becoming is understood as an openness to difference between not only human beings but also the physical space in which we exist. They argue that Deleuze:

> entices us into the ongoing practice of becoming–opening ourselves to difference in ourselves and in the other, the other being not just other human beings, but the physical objects, landscapes and other materials and intensities with which and in which we take up our existence (Davies and Gannon, 2009, p.-5).

This Deleuzian concept has relevance to rural family therapists because of the recognition of the significance of rural landscapes and contexts upon family therapist's practices. A Deleuzian "theory of becoming" (Durie, 2009, p. 133) includes an understanding of change and of perceiving problems and their solutions differently, in that:

> while problems differ in kind from solutions, they nevertheless do not exist apart from their solutions. Rather, the problem 'insists and persists in the solutions' … The problem is at once both transcendent and immanent to its solutions (Durie, 2009, pp. 132-133).

An example of the complex relationship between problems and solutions is described by Durie (2009) while outlining a Deleuzian concept of 'lines of flight', whereby new possibilities of change and difference are created by the relationship these concepts have to each other. Thus:

> the more a state seeks to impose rigid bureaucratic order on its society, the more it seeks to stave off change, the more it creates possibilities for escape … These possibilities for escape Deleuze and Guttari call lines of flight … [which] exist as virtual tendencies which groups or individuals actualise by actively exploring them (Durie, 2009, p. 135).

For Davies and Gannon (2009) these “lines of flight, these slides toward the not yet known, are moments of *becoming”* (p.64, italics as in original). They are created and emerge from:

> …a dynamic relationship in which chaos and order co-exist. Order may generate a safe place in which creativity and innovation can be fostered, leading to the transformation of matter and life in unpredictable ways…safe spaces are a necessary base-an orderly plane-from which creative transformations can emerge. At the same time, the evolution of life emerges, not from uniformity and sameness” (p. 1). Rather, these creative transformations emerge from differences with each other and associated physical objects and landscapes.

In a Deleuzian sense of becoming, Dorothy opened herself up to understanding difference in herself and the families she worked with, while acknowledging the significance of the rural context within which she and families lived and worked together. While she had already been visiting families in their rural locations, her main treatment approach as a “p*sych nurse*” was informed by the then medically dominated health system. This system was in a Deleuzian sense, a space of safety prescribing her actions as a health practitioner. However Dorothy witnessed the inadequacy of this system in not understanding her clients as being connected to, and part of their families and wider rural communities. Individuals were labelled as mentally ill, requiring medically treatment, such as hospitalisation and medication. For Dorothy she wondered if there was something more she could do outside these medically based treatments “*And I, so I thought there must be something that you could do with families* [to help them]”. In seeking new ways of understanding and working with families with mental illnesses, Dorothy found family therapy which she shared with her families. At the same time she let go of medical aspects of her “*psych nurse*” role, which legitimised her authority over families and their treatment (Davies and Gannon, 2009). For her this was a moment of ‘becoming’ in which she moved away from her safe practices as a “*psych nurse*” undertaking a Deleuzian ‘line of flight’. She moved from her previous safe space of traditional medicalised treatments of mental illness with families as a “*psych nurse*” into new, creative and innovative ways to understand and work with families utilising family therapy

concepts together. For Dorothy, systemic practices learnt during family therapy training moved her conceptually beyond a medically driven model of care as a family therapist. She move into new spaces of understanding her clients and their families, while acknowledging the rural contexts within which they all lived together. These new understandings allowed her to move beyond medical understandings of clients as merely unwell individuals requiring treatment. She was now able to conceptualising clients as part of a wider system, within which she was able to utilise family therapy practices to support them, their families and communities. For Dorothy this conceptual movement meant that "*instead of going to peoples' funerals*, she "*started going to peoples' weddings*" as more young people survived their mental illnesses and celebrated their lives.

7.6 Chapter summary

This chapter has presented a story of transformation, change and a Deleuzian sense of becoming for one rural family therapist, Dorothy, as she embraced family therapy theories and principles within her "*community psych nurse*" practices. Theories from family therapy transformed Dorothy's mental health practices with families and this chapter offers an intimate account of her experiences of a Foucauldian resistance while doing so. Dorothy's story describes how she deepened her connection with her clients and families using family therapy principles, to deal with the challenges of mental illnesses and suicide. She offers understandings of the importance of rural "*connectedness*" for family therapy practitioners, families and communities in her concept of "*gossamer threads of relationship*". Her examples of these connections add depth and compassion to a new counter-narrative of rurality as relational, as part of my ongoing analysis. Additionally, her story highlights the significance of building a "*critical mass*" of rural therapists to allow for changes in developing a more compassionate and systemic understanding of the difficulties families experience.

Chapter Eight

Rural family therapists working with differences of race, culture, class, rurality and gender.

> After the murder of one of McMillan's shepherds [by Indigenous persons engaging in guerrilla warfare in response to European colonisation] the retaliations [by European settlers] probably intensified to the degree that the Kunai [local Koori peoples] were constantly hunted and shot on sight ... It should be emphasized that the numbers killed in the early days were much larger than has previously been thought ... Due to the initial secrecy uninformed observers were forced to explain 'heaps' of bones as either burial grounds or as a result of tribal warfare. These observations have lead later historians to overemphasise the casualties caused by tribal warfare and to underestimate or not even mention the causalities caused by these early massacres (Gardner, 1983, p.52).

8.1 Introduction

This chapter explores further our Gippsland focus group conversations and narratives. These stories highlight issues of working across differences of race, culture, class, rurality and gender for rural family therapists. Narratives are presented in chronological order. Differences within these stories accumulate during their telling, so that an increasingly complex understanding of the significance of these issues to our professional practices evolves. While issues of difference are presented individually within my participants' narratives, my analysis brings them together to demonstrate their interconnectedness as part of intersectionality theory (Davis, 2008; Valentine 2007). Stories from James, Daisy, Anna and I include our struggles to understand issues of racial, cultural and class differences while working as white practitioners with Indigenous families, as part of our chosen social justice agenda. To ensure we understand these stories from the perspective of the participants, and because of the richness and paradoxical simplicity that is detailed in them, I am including long sections of the interview transcripts. I wish to acknowledge the courage and commitment of my fellow focus group members

working within this complex space and I thank them for their stories which created the foundation of this chapter.

My approach to analysis is again a layered one. Firstly, from my own understandings of intersectionality theory, I highlight issues of oppression and its connection to differences of race, culture, class, rurality and gender within our focus group narratives. A thread which runs through all of these stories is one of James, as the main narrator, searching for a theoretical framework to guide his practices of social justice, and his struggles in achieving this. This thread is representative of all of our experiences as Gippsland focus group members. As such, this thread becomes an important sub-theme, contributing to a new narrative of our resistance to predominant white, westernised ways of working with Indigenous families.

Secondly, from my dinner part conversations with Jacques Derrida (1982) and Michel Foucault (1980) I deconstruct issues of power, and resistances to this within our narratives to highlight alternative understandings of particpants' therapeutic practices in rural settings. These understandings include how participants are resisting dominant white Westernised perceptions of gender, racial and cultural differences within their professional practices. I further utilise Foucault's concept of problematisation (Neal, 2009) to explore James' struggle to work respectfully with Indigenous families locating his efforts within wider sociopolitical and historical contexts. These contexts include a history of the colonisation of Indigenous peoples, nationally and international, and a privileging of Westernised white knowledges during this time (Green & Sonn, 2005; Smith, 1999; Young & Zubrzycki, 2011).

I use the terms Indigenous clients and families and Non-Indigenous clients and families, as well as "*Koori time"*. These terms are those used by my participants and therefore to respect them, in line with PAR, I utilise these terms in my text. Similarly, it is important to note that Gippsland participants refer only to Indigenous families within their own region during their stories. Again in respect to participants, I predominantly refer to Gippsland Indigenous peoples' histories. I do, however, acknowledge that there are numerous other national and international Indigenous peoples' histories of colonisation. I have included a brief section on national and international Indigenous peoples' experiences of colonisation. I do this as an

acknowledgement of the multiplicity of international Indigenous peoples histories, while respecting local Indigenous peoples referred to by Gippsland participants.

Participants in the Gippsland focus group shared their stories with each other and myself as a fellow participant as part of PAR. Participants and I talked back and forth to each other while considering my initial research questions and subsequent practices and experiences of rural family therapy chosen by them. One participant, Daisy, was absent during one of the group's five conversations. I wish to acknowledge that her presence was a vital part of the groups conversations overall, despite her lack of representation in aspects of these stories.

My involvement as a collegial focus group member was more evident within these research conversations than in individual interviews or small group interviews with my other participants. This was due firstly to the ongoing nature of this group, which fostered ongoing dialogue over twelve months, and secondly because my previous professional connections to these group members facilitated an intimate connection to them. An example of this intimacy is that I have known my fellow participants within this group for over ten years in my professional roles as a psychiatric nurse and rural family therapist. In addition, we have shared clients together across our workplace organisations and family therapy practices.

My Gippsland fellow focus group participants and I met in a negotiated space at a local health service. Often we would arrive at varying times, despite prior planning, because of the nature of the work we were involved in. For example, on one occasion a participant had an emergency with a client which needed attending to, so she was running late. She had notified us of her late arrival by a phone call. Our usual practice was to wait until we were all present before we began the formal part of our interview. While we waited we would talk together about our professional practices and personal lives and connections. These discussions strengthened the bond we had together as research participants and is consistent with feminist research principles (Reinharz, 1992). We had been talking prior to this interview, while awaiting our last member's arrival. When we were all present we began talking about a training day that James had been to, that he was excited to share with the group. He began his story by telling us about a barbecue event which highlighted for

him some of the cultural differences between Indigenous and Non-Indigenous groups and communities he had noticed in his professional practices.

8.2 “They had a BBQ”

James: *It’s like the Indigenous barbecue (BBQ) story we were hearing yesterday. Um, $11,000 or something was granted to build a BBQ area and then a couple of weeks later they* [*the governmental sponsors*] *went to see how the BBQ was coming along and the* [*local Indigenous*] *elders said, ‘No mate, you’ve missed it, it was a couple of weeks back, it was a ripper!’* (All of us laugh together). *They* [local Indigenous peoples] *had a BBQ but they didn’t build anything, they just…*

Anna: *Ah, just a meal, $11,000 for a meal…*

James: *That was the story, yeah it’s just that you know, from far and wide probably and they had, they had a BBQ…*

Annette: *Was that a cultural difference of interpretation?*

James: *Yeah, that’s right, you know we were talking about the, um, this was in the poverty* training [Bridges Out of Poverty Training] *stuff, yeah that’s right, that’s what it was. A staff day talking about the, um, formal versus informal language and what’s the word they use?*

Annette: *I’m not sure.*

James: *Ah, it’s on the tip of my tongue…*

Anna: *That it’s like perception?*

James: *Register…*

Annette: *Oh yes…*

James: *So they talk about, most of us in our work, we work in a formal register. We use formal language…*

Annette: *Oh yep.*

James: *Um, casual register, ah, formal language but with a bit of, probably more like what we are doing now, or what we might be doing with the camera off, um, and then, oh golly I don't know, there's five different ways of communication…*

Annette: *I'm guessing you're meaning much more informal as you* [go] *down the scale or something?*

James: *Yeah less formal and, um, down to, and they're* [generational poverty trainers] *saying people from generational poverty, and I find this all a bit boxy, but essentially they're saying there's generational poverty, there's middle class and there's, ah, people with money, um, and that the language and the registers are very different, so when a middle class person says to a generational working class group 'We've got money for a BBQ', this is what happens…*

Anna: *Yeah, yeah…*

Annette: *And it was a ripper.*

Within this paradoxically simple and humorous story, differences in culture, race and class are revealed in language and differing interpretations of this. James explains his own understanding of why these differences occurred, utilising a theoretical framework to explain class structures from Americans Payne, DeVol and Smith (2001), offered to him as part of attending The Bridges Out of Poverty training (http://socialsolutions.com.au/workshops/bridges-out-of-poverty/).This training has a specific focus on how professionals might create opportunities for marginalised populations to move away from generational poverty.

Utilising this new paradigm James describes how differences in language of informal versus formal registers, between local Indigenous peoples and non-Indigenous metropolitan sponsors, resulted in a different understanding of having a BBQ event. James' understanding of the people involved was that for the Indigenous families a BBQ meant gathering together over a meal. This understanding fits within an Indigenous culture which privileges communities and families supporting each other at communal events involving food (The Australian Insitute of Aboriginal and Torres

Strait Islanders Studies [AIATSIS], 2008). For the Non-Indigenous sponsors' a BBQ meant the building of a cooking area, rather than simply having a communal gathering at a one-off event

Calling upon intersectionality theory, I offer an alternative understanding of this BBQ story as one of interconnecting issues of oppression for the Indigenous peoples involved. This theory, introduced previously within my discussions with theorists, offers important considerations of the connections between peoples' oppression in relation to their differences of race, culture class and gender. Kimberle Crenshaw has been credited for the initial creation of this theory (Davis, 2008; Valentine 2007) when she rejected:

> …the notion of race, gender, ethnicity, class and so forth as separate and essentialist categories, [and] developed the term *intersectionality* to describe the interconnections and interdependence of race with other categories…[She] theorize[d] the intersection of race, gender, and class for black women. She adopts an analogy with road junctions where violent accidents repeatedly occur but are never reported (Valentine, 2007, p.12. Italics as in original).

Intersectionality theory is an analytical tool (Tomlinson, 2013) and a "...way of thinking about the problem of same-ness and difference and its relation to power" (Cho et al., 2013, p.795), which I apply to narratives within this chapter.

This barbecue story is a practical example of the synergy of intersectionality issues at work, in the everyday lives of an Indigenous community. That is, differences of race, culture and class coming together, creating complex layers of misunderstandings between Indigenous people and Non Indigenous sponsors over a BBQ event. Further, a deconstruction (Derrida, 1982) of issues of power and resistance (Foucault, 1980) intrinsic to this story, reveals a dominant narrative of non-Indigenous peoples understandings of a BBQ event, being privileged over a subjugated narrative by local Indigenous peoples understandings of this event as an Indigenous community connectedness. This is the beginning of the sub-theme within this chapter of James's struggles of enacting socially just practices with his Indigenous clients, which expands during his narration. Our group continues to

explore issues of difference between ourselves and our clients, delving further into our understandings of class structures.

8.3 “We’ve come from that sort working class background and [have] gone off and got ourselves educated”.

James continues his story from his last comment.

James: *I find it a bit funny that there was no kind of written anything about what that actually meant, but anyway it was a* (I can’t hear the words he says here)…

Anna: *Somebody else was um.*

James: *And its valuable sort of, it’s a bit of a side-track sorry.*

Annette: *No I think it’s interesting.*

Anna: *Yeah*.

James: *Interesting to look at that, yeah poverty um. What is it,* [the] *Bridges Out of Poverty training? A number of people have done it and the schools have found it incredibly useful.*

Annette: *Who is doing that James*? (I look at James and ask this in an inquiring tone).

James: *Ah, I can’t give you a name*.

Annette: *Private people or education driven or*?

James: *It’s been put together, privately pretty much. Some of its been put together by some doctor, who I disrespectfully can’t remember the name of um. And it was presented by, you know a team that go round presenting it. And we got the sort of couple* [of] *hour’s version of the two day training. And it was, yeah quite interesting. Just to revisit your perceptions about how people interpret what you said.*

Anna: *Yeah, what you are saying, yeah.*

James: *And how our clients hear us and how we hear them and um, yeah*.

Annette: *Because it would still be the majority, I'm still thinking about the conversation about our change of clients* (I say this to Anna). *I'm thinking with James still working with* (name of their agency K's) *clients*. *My understanding of most of K's, or the majority of K's clients that I've worked with or liaised with is that they fall into that lower socio-economic kind of group and have multiple, sort of complex problems. So it is interesting to hear you are working with a different group, it's a bit of a challenge.*

James: *But you're, you know, middle class citizens in* K.

Anna: *Yeah, yeah.*

James: "*We need help and you're the people we go to for help*" (James adopts the voice of clients coming to his service here). *And um it's a real challenge when it's...*

Anna is so keen to speak that she starts to do so as James finishes this sentence.

Anna: *And um, I think I mentioned last time there's one particular client referred to me by a psychologist. She would be somebody who I would actually put into the higher* [class and income] *bracket. So she's that first person that I can say that I have worked with in that higher bracket and that in itself has been really interesting yeah.*

Annette*: I'm Interesting in that, in terms of relationships with her, or the therapy*? *Or*?

Anna: (Pauses for four seconds while looking thoughtful). *I'll have to really think about that I suppose.*

Annette: *That's ok you are allowed to.*

I say this with humour as I look at Anna to allow her time to think.

James: *I think you know of these people as, I had this image*.

Anna: *Yeah, I've always, I've always had this perception that people that come from there* [region her 'higher class' client came from] *because I class myself here [in her agency] as* …

Annette: *As in terms of affluence? You're talking about financially here and you here?*

I ask Anna this to clarify that what she is discussing is class related to income levels for herself and client she speaks of. This relates to previous discussions with the group of the Generational Poverty training.

Anna: *Yeah as being obviously people who can cope well and are intelligent. And um it's probably a silly perception but I've always had this feeling like they, they can deal with things better and they can't. And she* [her client] *was really, and still is really very susceptible to um to the questions that I ask. And to, not that I try and advise, but to things that I say. She really seems to listen, yeah, it's empowering for me* (Anna laughs).

James: *Yeah, and it's doing* (I can't hear the word he says here) *when you do. I'm like that too. And I struggle when I get someone who is a bit well to do. Or you know comes in and this instant feeling, who am I to give you advice kind of thing, or to work with you. And that, I've learnt to deal with that you have to. Because um that kind of a distortion really by um. We recently come across someone who was doing the K work. [A] child's behaviour is out of control so they* [the parents] *were in the parent group for K and I'm running the parent group. They are a professional in the community and they have actually applied for a job at K doing what I used to do.*

Annette: *Talk about even more complicated*.

Anna: *Ha.*

Anna says this with emphasis and humour to support my comment.

James: *So that there kind of relates. And sort of, um that was someone who was really, who had their heart on their sleeve. "I really need help and I can't*

manage". And it was actually quite nice, no illusions. There was no tension about, "I'm a professional so don't try this on me. It was very much coming saying, "Sure I've got this [professional] *job but help".*

James adopts different voice to represent what his client said, in the sentences in quotation marks. He laughs wryly as he finishes these sentences.

Anna: *It's sort of almost like we expect, we're expecting them* (James speaks as Anna says this at the same time).

James: *It's very*…

Anna: *To do that or to say that almost. It's our own perception that's the problem here.*

James: *You do, you kind of, and maybe because that's right because we've come from um assuming, based on what you said* (James says this to Anna and looks at her). *That we've come from that sort working class background and* [have] *gone off and got ourselves educated. And um, but you can't take the boy out of the country sort of thing.*

James laughs at this expression as he says it.

Anna: *That's right, yeah that's exactly right*.

James: *And that's you know, something that came through in the training you know yesterday as well. Talking about um. And we would think it about as family of origin stuff* [from family therapy]. *But it's interesting to think about it in terms of class. Quite distinct from family of origin and looking at you know, when you are really accepted. You know what is the language that makes you accepted in a certain class group. And I really hate class group but it's a useful paradigm to think about some things. … And they talk about working class communication* [in this training as] *very non-verbal and physical communication. You know, blokes around the BBQ with their beer kind of thing.*

Anna and Annette: Yeah (said together).

James: *Who don't talk a lot necessarily. And if anyone gets out of line they are likely to get thumped. Middle class is much more, there's much more communication. And more, "I'm not really happy that you spoke like that to me so let's have a bit of a talk about that". And it could still get ugly. Upper-class you get a letter* (James laughs).

Annette: *You get a letter*? (said in inquiring tone to clarify what James has said).

Anna: *From the solicitor*.

James: *Yeah, "My lawyers will be in touch with your lawyers" kind of thing. Yeah because you've offended me and that kind of* (James doesn't finish his sentence here).*That, that is very broad and sad but yeah that kind of…*

Anna: *I think it was* (name of person R), *somebody else when I was working at K. Sorry I really gotta say this*.

Anna says this to James, then looks at me as she realises she has used names of people she knows and has concerns about their confidentiality. I reassure her by saying:

Annette *Don't worry because the names come out as you would have seen from your last transcript and I put a letter in.*

James: *Right, ok* (Says this in acknowledgment of Anna apology to him and my comments re confidentiality).

Anna: *And I don't know whether you've heard this as well or not*?

Anna laughs and then says this statement to James, as she again begins to talk about the Bridges Out of Poverty training he attended, which she did not attend but has leant of through others in her agency.

Anna: *But she had pointed out that she went to a training where um, if you really wanted to get at somebody from a low socio-economic background you would do something, take their children away. That would really hurt them. But if you did it to somebody from the middle class, I've got to remember what*

it is now, from the middle class you would take their money away. But if you did it to somebody in a higher class you would um give them a bad name.

James: *Yeah, that fits*.

Anna: *That's always stuck in my mind.*

Calling upon my previous relationship with Anna, and experience as a family therapist, I have noticed a very different tone of voice and language in some of the sentences she has used. Her tone and words are somewhat punitive, which is not how she normally speaks of clients. I wonder what this is related to, suspecting that it is part of the style used in the Bridges Out of poverty training, which she later confirms for me. I ask her about this tone:

Annette: *Something about the prestige that goes with this* [meant something to] *you*?

Anna: *Yeah*.

Annette: (speaking to Anna) *I'm really struck by that language when you were talking about the R person. I don't know when you were speaking about her before, the language, you know, "If you want to get at somebody".*

Anna: *Yes*.

Annette: *It's quite*.

James: *Yeah*.

Anna: *I probably used harsh words but that was what was said. It could have been twisted around the other way too, if you wanted to help somebody...*

James: *It's about what they value, what people value.*

Anna: *Yeah the value of it*.

Annette: *But it was just, just interesting because for me your language is not like that* [normally]. *So I picked it up its more, how it came across* …

Anna: *Yeah*.

Annette: *Because that quite um, I don't know. That's quite a tone to me, that's part of that real injustice stuff.*

Anna and James: (Together) *Mmm*.

Annette: *You know where upper-class women*, *whoever they deem themselves to be, we will help you* [to those] *from another class. Yeah, so therefore you are a lesser person.*

James and Anna: (Together). *Mmm*.

Annette: *That's interesting stuff. So obviously you know about this poverty stuff as well that James is talking about*? (I ask this of Anna as I look at her).

Anna: *Not to that length, no and I haven't done training in it, it's only what I have picked up from other people, yeah, it's really interesting*.

The punitive tone of voice I have noticed with Anna, which is notably different to her usual tone, is an important one. This tone is part of her own understanding of the Bridges Out of Poverty Training from discussions with her colleagues. This tone, as part of her expressive language (Riessman, 2008) drew my attention in the next layer of my analysis.

8.4 The 'Titanic' movie as a metaphor

James and Anna have a very animated discussion together. James uses the popular media movie, 'Titanic' as a metaphor to explain to Anna and me his own understandings of class structures learnt from attending the Bridges Out of Poverty training. Anna quickly and enthusiastically takes up this Titanic metaphor, adding her own perceptions of class structures. James and Anna talk quickly together, making full eye contact with each other, frequently laughing and smiling at each other during this part of the conversation.

James: … *And I can relate that to what they are saying about um. If you are not a native to the language and the interaction then when do you really fit, when do people, people know you're for real? It's like old money and new*

money kind of thing. That's another concept they talked about. Old money is just valued for that, they are, and while they were talking yesterday I was thinking about the 'Titanic' (movie) *and those kind of stories.*

Anna: *Yeah, yeah*.

James: *About it doesn't matter that you're absolutely destitute and you owe millions of pounds.*

Anna: *You have the stature.*

James: "*I am lady such and such*" (James adopts a different voice while repeating words in quotation marks, then he laughs). "*And I have this status and that's it*". *Whereas if what's his name owes the butcher two pennies he's gonna end up in jail*.

Anna: (Looks at James as she says this, smiling) *And with 'Titanic' specifically there was that other larger lady who as really down to earth and helped Rose out, remember that*?

James: *Yeah the ah*.

Anna: *And she had all the money*.

James: *The unthinkable oil*.

Anna: *They had hit oil, they had struck oil, I remember that.*

James: *That's right, and she was the new money.*

Anna: *And yet* [despite] *that she wasn't accepted*.

James: *It didn't matter, no*.

Anna: *They didn't want to hang around with her because she was new money I think*.

James: *Yeah new money*.

Annette: *I was really struck*.

James: *Didn't matter that they were old money with no money* (James laughs at the irony of this).

While James and Anna's animated discussion of the movie 'Titanic' called upon fictional characters, the class structures portrayed within this performance bought to life characterisations of class taken from wider social contexts. Class was viewed as a hierarchical structure. Higher class people were situated at the top of this structure and in the ship 'Titanic' itself, with the most privileges in terms of social status. The higher class was then further refined into new money and old money, with older money having the higher social status. The middle class existed below higher class, both within a class structure and on the ship, with fewer privileges than the higher class but still above the lower classes who occupied the bottom of the class structure and the ship, frequently in roles of service to the other classes. James and Anna's metaphor of class structures within the 'Titanic' vessel, provides an interesting and accessible understanding to practitioners of not only the hierarchical nature of these structures, but also the inherent issues of power and privilege between each level of these

Taking up a theoretical framework offered from The Bridges Out of Poverty training allowed both James and Anna to reflect on the focus group's status as middle class therapists working with "*working class*" families. Their stories are representative of all of our group experiences and collective reflections on how our own class status influences our therapeutic practices as therapists. Calling upon an extensive history together as professional colleagues, James describes the journey we have undertaken, as Gippsland focus group participants and the changes in our own class status, moving from working class backgrounds into middle class professional status as therapists. This move was facilitated by our accessing formal education. James perceives this movement between social classes, from working class to middle class, as helpful for the therapeutic practices of our Gippsland focus group, as it allowed us to develop a wider perspective and understanding of issues of class. His story is part of our group collective narrative of understanding issues of class for a group of previously working class people, moving into a more privileged middle class status as white family therapists. While our experiences have allowed us some understanding of differences in class structures, neither our previous or current class

status has provided us with any insights into cultural and racially differences between ourselves as white practitioners, and the Indigenous families we work with. What is required is understandings from intersectional theory to be applied to our own privileged positions as white practitioners working with marginalised and oppressed Indigenous families. I consider this application as part of my final analysis and discussion in this chapter.

Given the richly descriptive details within our remaining Gippsland stories, I present these stories in their entirety within concise sections of the interview transcripts. I only interrupt these stories to briefly identify relevant intersectionality issues and provide readers with contextual prompts. These stories contain important conversations and reflections by participants and myself in relation to intersectionality issues, and their theoretical significance to our therapeutic work with clients.

My final analysis deconstructs (Derrida, 1982) our stories as a collective tale of issues of intersectionality and locates us, as rural family therapists, between the complex spaces of these issues and our clients' lives. In addition, I present a problematised history of the colonisation of Australia's Indigenous peoples, from my own understandings of Foucault's theories of power and resistance. I include a brief account of international Indigenous peoples' experiences of colonisation, as an acknowledgment of the diversity of their colonisation experiences. This section of my analysis situates our Gippsland stories within wider sociopolitical and historical contexts, from which emerges new understandings of our therapeutic work with rural families. These families include oppressed Indigenous peoples, and other marginalised populations. For example, families who are poor, mentally unwell and suicidal adolescents and male farmers impacted upon by the Black Saturday 2009 Gippsland bushfires. These stories further strengthen an emerging counter-narrative of rurality as contextual, relational, diverse and complex.

8.5 "I haven't been able to get there [counselling] with the men"

As part of another subsequent focus group conversation Anna discusses her work as a female bushfire counsellor to male famers after the Black Saturday 2009

Gippsland fires. Her short story adds a further dimension of gender to our discussion of intersectionality issues. Her comments are representative of those made by all of my female participants on the role of gender in our therapeutic work with male farming clients.

> Anna: *As a female I felt that I haven't been able to get there with the men. And I've actually had to transfer some clients over to our male case manager so as, to see if he can. And he's discovered that working with them is actually best by going out helping them rebuild their fences. Go out there, do that physical stuff with them and while they're doing that physical stuff that they're actually um, starting to talk. But for us working within the structure of K, I would never have had the opportunity, such as working with the Indigenous woman and going down to the river, to be able to do that without the safety aspect coming in. So I've always thought, I just can't go there working in this role but now it's coming out.*

Anna's gender as a woman became an issue of difference and intersectionality for her, and her male clients. In recognising and acknowledging this she was able to co-opt the assistance of another male counsellor to successfully work therapeutically with this group of clients. Issues of gender have been well recognised in family therapy for some time such as, Goldner (1985a, 1985b, 1988) and Luepnitz (1988). Anna's role of counselling families experiencing domestic violence was further complicating by additional intersectionality issues of class and cultural differences, discussed outside our focus group. In hindsight, a theoretical understanding of intersectionality issues would have been a valuable addition to our focus group conversations. However our knowledge at that time did not extend to being able to articulate the issues of difference we were experiencing as those of intersectionality.

Anna's story is an important one because of her attempts to engage with rural male clients, who were predominantly farmers. This group of males has been identified as a population at high risk of suicide, as noted in my literature review (Alston, 2012b; Alston & Kent, 2008; Maidment, 2012; Misan et al., 2008). This male population is also difficult to engage in seeking or accepting help, related to concerns of stigma for them in doing so (Alston, 2012b; Alston & Kent, 2008; Maidment, 2012). Given the

high risk of suicide among rural farming males, this group continues to be an important population for therapists to engage with, which focus group members were aware of. Anna's new way of working with males is an important finding within this study. It offers counsellors, family therapists and other health practitioner's new ways forward in engaging with rural male farmers. By recognising issues of gender, and understanding aspects of identities taken up by rural male farmers, practitioners can work towards an enhanced engagement with this group.

8.6 "It's a ghetto"

Later in our same focus group conversation.

> Annette: … Anna wants to say something, can I just ask something to clarify first?
>
> Anna: Yeah.
>
> Annette: *Just for a bit of context, when I used to work in the region here* (Name of suburb, Z) *was still the area where a lot of* (Name of metropolitan city) *mums, particularly single mums were sent out* [to] *because partners were in the local prison. So they would be sent here to get housing or whatever. Does that, is it still that kind of demographic, still or*?
>
> James: *I think they are trying to break that down a bit yeah but Z, you know is.*
>
> Annette: *A small ghetto in American language*?
>
> Anna: *Renowned for*… (James speaks as Anna says this).
>
> James: *It is, it's a ghetto and it's an absolutely tragedy of town planning. I don't know, it's the saddest thing I have ever seen. But um in terms of this little isolated group, it was designed as public housing um cut off from (*name of local town) *by the river. And the only way into (*name of local town) *was over the causeway or to walk over the railway.*
>
> Anna: *Yeah, no public transport*.

James: *And which of course is a very bad idea um and no, and they periodically attempt some sort of ah funded public transport. You know the shire tries to get a bus up and running. But people don't use it enough you know because they need it when they need it, not at set times*.

Anna: *Set times*.

James: *Which are limited because it's a low budget thing. So anyway yeah, essentially it still is* [a ghetto]. *But I think with public housing in general they are trying to spread public housing out in the community rather than have it in isolated pockets*.

Annette: *A satellite* [region]?

Anna: *Because it's so much better, if they could do that.*

James: *But with Z, you drive in Z it will never be any different. It's all little cream brick housing commission houses. You're not gonna, that's what it's gonna be.*

Annette: (I look and speak to Anna, to go back to what she wanted to say before this part of our conversation).

Annette: *Now Anna, I distracted you*.

Anna*: I can't remember, I was sitting here thinking what I was going to say, it will come back* (Anna laughs).

The "It's a Ghetto" story is significant for practitioners wanting to understand and work with intersectionality issues at two levels. Firstly, the ghetto story contributes to practitioners' understandings at a practical level of how intersectionality issues of differences of race, culture, class and gender differences converged to further marginalise a low-socioecominic group of families. For example, female clients seen by focus group members were oppressed as women because of their gender, in addition to their oppression related to their lower or working class status. In addition, for our Indigenous clients they also experienced further oppression because of their racial and cultural differences to the nearby township of predominantly white people.

This dizzying array of complexities compounded our client's already marginalised position as individuals. Other intersectionality considerations that could be included are those of the status of their children and male partners housed in the local prison service.

Secondly, this story raises the issue of rurality and associated geographical and personal isolation experienced by these families in their relocation from a metropolitan centre, with numerous services and family connections to an isolated rural "Ghetto", with no public transport and poor town planning. Metropolitan services chose to reallocate families to this Ghetto suburb, when their partners were imprisoned, in what they consider a local setting. Public housing was specifically grouped together in this location, creating its "Ghetto" status. There is no public transport from this suburb to the local town or prison centre. Families reallocated were already marginalised and oppressed, experiencing numerous intersectional issues raised in my discussion above. Rurality, and its associated geographical and personal isolation further compounded the marginalisation of these families. Their rural context had limited access to health services and clustered them together in public housing with inadequate access to their local town, or their imprisoned partner

While cultural, racial, class and gender differences are acknowledged within intersectionality literature (Davis, 2008; Yuval-Davis, 2006), the challenges of rurality are not. The rural isolation experienced by families in the "It's a Ghetto" story, contributed significantly to the personal distress experienced by these families. As Gippsland participants we witnessed this distress, discussing how to address it outside our focus group research conversations. In addition, working within a rural context has had a significant impact upon the practices of members of the Gippsland focus group. The lives of clients, families and family therapists are significantly affected by the rural contexts within which we live and work together. Rurality shapes us as people and our therapeutic practices as family therapists, as reflected in participants' stories included within this study. Consideration of including rurality, as an additional intersectionality issue, would allow practitioners access to alternative understandings of the challenges rural populations face. Including rurality, alongside other well-known intersectionality issues such as, gender, race class and culture, provides an important opportunity for family therapists to develop new

understandings of clients, families and family therapists who live and work together within these rural contexts.

8.7 “We’ve bought a bird”

Later in same focus group conversation.

> James: …*We were talking about this at the staff day. All you need to do is help* [clients] *but it’s not how it works. And that stuff about if, you know, if you, 80% that’s a good stat*[istic] *that came out 80% of people who win tatts lotto. Now I forget the timeline but I’m gonna say two years. Say two years down the track they are worse off than before. I found that 80%, I mean I could believe that in a number of cases <u>but 80%</u> that’s incredible and that’s about that stuff in generational poverty. If I get money it’s about* (James snaps fingers) *spend up, you know* (Underlined words said with strong emphasis in an incredulous tone).
>
> Anna: *Yes*? (Anna looks at James enquiringly while he says the previous sentence, then adds her own comment). *Or give it to other family members*.
>
> James: *Or the baby bonus where did that go*? “Y*ou know we talked about what you were going to do with this*” (James adopts another tone in his voice to represent how he spoke these words to his clients). *And she* [the training presenter] *gives the example on stage of you know of buying a car. All they* [the clients] *needed was $900 to buy this car. And they scrimped and saved and this happened and they had a windfall. And they got the extra money to buy it.* [The counsellor then said to this family]*, “So when are you getting the car, when are we going to go and look at it?”* [*The family replied*], *“Oh um, we’ve bought a bird”.*
>
> Annette: *A bird*? (I ask James this question in an enquiring tone as I’m unsure what buying a bird means).
>
> James: *A bird, and they bought a bird in a cage for $800. And that’s what happens, I've done it, my clients have done exactly the same thing. I’m sitting there laughing, thinking why am I laughing, and that’s not funny.*

Annette: *You were recognising it*?

I am asking James here if he is recognising this buying a bird story from his own therapeutic work with low income families at his agency.

James: *She said yeah, yeah sure whatever. Because yes you've got these guys in public housing, they've got bills up to their ears. They have got, you know, they owe their parents they owe here, they owe there. They get money and they blow it on kid's motorbikes for Christmas with the baby bonus, you know things like that. And this is <u>after you've</u> done all the, "Ok we sit down and we plan a budget, we talk about strategies, we talk about what we might do* [with the parents]*". None of it counts for anything*. (James's words underlined said with a strong emphasis).

Anna: *That's almost, comes back to the um.*

James: *It's really, you know it's hard not to judge, you know.*

Annette and Anna (Together) *Yeah, it is*.

James: *It's just interesting*.

Anna: *That comes back to that, if they come from the lower socio-economic background the child comes first, isn't it? Almost like the bills can wait, they are always there, they are never gonna go away, so I'm gonna buy the kid the motorbike*.

James: *Yeah that's right, none of that's ever gonna change. But I love my kids I'm getting them something, you know. Or the kids want the bird, probably, I wonder, it would be really interesting to know if the kids had any part in that wouldn't that, in getting the bird, in that example*?

Anna: *Yeah, for them that is probably what is the most important thing, they don't care or understand about the bills*.

Later in our same focus group conversation.

Annette: *I'm also wondering when I am listening to you guys particularly when you were talking about that generational thing. You do all that work James, you do the budget, you do all the things and they still go and buy the motorbike or buy the bird. Um, is there more to it? I always wonder if there's more to it than just the therapy. If there's another part of our role and that's the political social stuff. You know, what I mean? It's that whole thing you raised about class, and um*…

Anna: *Yeah, I think that um part of that is that we do class ourselves as middle class. So for us that finances are really quite important, how we deal with the finances are really important. And we can't understand why they* [clients] *don't see that being that way. So it's a perception of what we've got about what should be happening for them. Whereas for them they might be indicating they need this and that and they have bills up to here, but in reality the important thing is the child.*

James: *Mmm, yeah, that's right*.

Anna: *It's about reframing the way we think is that, I'm sorry I interrupted there* (Anna looks at James as she says this).

James: *It's that what it's sorta about. And I wish I had the notes because whew half of its in one ear and out the other. I need to look at it to remember it all but it's that's right, you know what each*… (Anna speaks as James says this).

Anna: *What is important to us may not be important to them, or could be vice versa.*

James: *You know middle class values. Particularly* [middle class professionals coming from] *working class where they are now. Where they have come from, where they can get to. They can see both ends of the spectrum sorta thing. So saving and being sensible with money is valued to some degree um. And then um upper, what's the term they use, not upper class even. I can't think but the next level, old money and new money whatever um, is about connections and status. Yeah status primarily, so you know they will spend*

huge amounts of money to maintain their status to continue to look important sort of thing.

This story is not only disarmingly humorous, it was enlightening for James. It connected him and us, as his fellow focus group participants to our own practice experiences of class and cultural differences. James was able to identify that his own middle class perspective of money differed to that of the working class generational poverty families he worked with. He, as a middle class person, valued money and the paying of bills in different ways to the families experiencing generational poverty. Likewise for Anna, she identified that her middle class status and ways of understanding were potentially in conflict with her clients' understandings, informed from their own working class status. James's and Anna's stories demonstrate their recognition of their privileged status as middle class, white Westernised practitioners working with oppressed and marginalised Indigenous families. This recognition is an important first step towards understanding this privilege so that it can be 'undone' (Pease, 2010).

8.8 "I'm a Koori man"

Later again in same focus group conversation.

Annette: …*And I can't help thinking there's more to it than just intergenerational poverty. There's the wider aspect of* [it] *politically. You know, politically why they are the way they are?*

James: *And I mean, as a fairly raw example of that, and it relates back to family therapy stuff as well*. *In K we are working with a group up there. And there's um an interesting couple there. They have been together, what um, he's Koori* [local Indigenous tribe] *and she's non Koori so this Koori family have been together fifteen years. With seven kids including a baby so kids from like fourteen down to a baby. Um so their relationship has survived lots of kids,* [there is a], *lot of value in their community for that. Ok things are not great but things are not terrible. They're not living in dire straits by any means. But he's just found out, and this is particularly an Indigenous thing I guess but it also speaks to families in general. He's just found out that his parents aren't who he thought they were.*

Annette and Anna: (together) *Ah*.

James: *He thought this is great because there was a bit of a community thing as I understand it, about doing some work around family trees and helping people to document their family and trace their family. And in the process he found out that his parents are not who he thought they were. He's now suicidal, and it's like life doesn't matter, if I don't know where I came from I shouldn't be here. And there was some show recently, there was a movie or something that had a hint of that in it. That, and I remember this for you know, Koori people, the Indigenous population it's very like, you know that roots and family are so critical.*

Anna: *Yeah, yeah* (Nodding in agreement with James).

James: *And understanding where you know, how you belong to the land, whose land you belong to sorta thing, where you come from. And I've always said, seen examples of Indigenous people speaking about that where they come from. "I'm a Koori man".*

Annette: *Koori Gunnai*? [Name of local Gippsland Indigenous peoples tribe].

James: *Mmm. And they rise and swell as they speak and you can see it. You can see in that moment, "I am proud". And then they go on to continue talking and nothing else is quite so important as um, who I am and where I come from. And this guy, yeah he's, you look at him and you think why. You've got, everything's fine. And it's not* [just him], *there's me, me him and you, there's five people here ready to help, none of it matters. He's you know in this deep dark place you know, um. And it seems to relate to that um that lack of, lack of ability to see hope in the future I suppose.*

Annette: *I'm guessing from what you are saying here, his parents are not as Koori as he thought they were, or*?

James: *I don't even know.*

Annette: *Because I'm wondering if it's the cultural link. You know he thought he had a heritage and connections and he thought, this is where he came from, this is what he could stand on to be proud, and it's not there* ?

James: *That's right and he's, whole other issues about you know, that maybe who he is now linked to he might not want to be because those family connections are equally important. But um you know what shines out* [is] *just the fact that he's not in his mind, not who he thought he was. And how much that impacts um and how hard that is to imagine. I said to someone at work yesterday you know …*

We are interrupted by a loud fire alarm noise and announcement over a speaker system, which distracts James. I explain to him and the group what this noise is, so they know we are safe, we don't have to evacuate and we can continue our conversation.

Annette: *That's just a fire alarm test. They are fire alarm testing is what they are saying. Sorry that distracted you. You actually reminded me of family therapy training when you were talking James. Because one of the things that went through my head was I don't know of many programs, training programs, well I am talking about Australia, that I am aware of that incorporate Indigenous peoples' perspectives. We do family of origin as you mentioned, structural, strategic, and feminist and all the different styles but I am not aware of any that particularly look at issues to do with Indigenous cultures.*

James: *Not really eh? We touched on it I think in, pretty sure* [name of family therapy centre's] *course did touch on it. Um might be confusing it with other uni[versity] stuff but it's yeah that's right. I think because we just don't get it, we don't understand it. And I have been part of the Indigenous task group at work for that reason because I don't get it* (James laughs). *So I figure the best way to try and get some insight and understanding is to be part of a group who is looking at the issues for how we work with Indigenous people. And um, that's what I was saying yesterday. I have a hard enough time getting my head around suicide at the best of times. For me to understand what it takes for someone to be in a place where they no longer want to live for tomorrow I*

can't, I can't bridge that gap, do you know what I mean? I really can't understand how that could happen.

The cultural importance for Indigenous peoples to be connected to their families, communities and land (Moreton-Robinson, 2000), without which they might not survive, was a concept with which James struggled. From his place as a Non-Indigenous male within a dominant white Australian culture, James could not understand why his Koori client would choose to die, rather than be disconnected from his family and community. James was able to acknowledge the importance to this Koori man of belonging to the land. He spoke of noticing that his client would "*rise and swell*" in his speaking of this connection.

While James understood this connection theoretically, he knew that therapeutically there was another level of understanding he had not been able to access within his existing models of practice. James was already consulting those individual Indigenous families he was working with, as to what would help them. He was however also searching for wider theoretical understandings of Indigenous cultures to inform his social justice work with whole community systems, such as, health and legal organisations whom his families also worked within.

James' professional training had provided him with theoretical frameworks and strategies for therapy practices, enhanced more recently by a generational poverty framework (Payne et al., 2001). This training offered James an alternative understanding of the class structures within which he and the families he worked with, found themselves embedded. While James' practice was enriched using this new theoretical framework, he continued to struggle to understand and work with issues of racial and cultural differences with disadvantaged families. The gap he was experiencing was that concepts from this framework did not sufficiently guide him in the dilemma he faced of being a privileged non-Indigenous, white middle class male striving for social justice in his work with culturally diverse and marginalised families. This was a painful process for James shared and witnessed within our focus group. James story was representative to us of our own struggles as white Westernised family therapy colleagues pursuing a social justice agenda with our Indigenous clients and their families.

James returns to the topic of Indigenous families:

> James: …*The biggest thing I learnt* [I] *guess in dealing with Indigenous families is, it's an extension of what we're considering to be generational poverty stuff. What's important in the moment is what's important and cultural. That's where you step from that into cultural and that, it's what matters. And I remember the story that finally drilled that through my head was about the spear making. And they, the Indigenous people making spearheads or whatever, they're making* [them] *and you know you spend half a day fashioning this thing. And then the end breaks off it. It doesn't matter, you start again, and it doesn't matter. It's done when it's done. We finish this when we finish it sort of thing. And it's, whereas we would be saying nine o'clock deadline* (James and Anna laugh together at this comment). *They say it breaks, they tell you that it's alright.*

This section of James's story speaks to his growing appreciation of the difficulties and failures by non-Indigenous peoples in attempting to understand Indigenous families. His figure of speech, "*finally drilled that through my head*", suggests that Non-Indigenous people's "*heads*" are perhaps not able to understand the lives and experiences of Indigenous people without a level of effort ("*drilling"*) to insert new understandings into them. His words acknowledge the failures in understanding the culture of Indigenous people by Non-Indigenous Australians without potentially some form of (metaphorical) violent change.

James continues this story.

> Anna: *I reckon*.
>
> James: *But um so I don't, you know. You can wonder how that all fits into modern society and what's changed and what hasn't. And what should and what shouldn't have but at the end of the day that the sort of thing that people will talk about. You know, that time, the way we measure it, isn't important. And that almost disrespectful concept of 'Koori time' that people bandy around. And they say, "Yeah they are on Koori time" which I find really, mmm*

(James laughs). On one level you understand what people are saying, but it just seems to be a bit flippant and disrespectful sort of. It's like they don't care, it's not that they don't care, it's that I guess to borrow a term from something I was reading yesterday, wired differently. It's not important you know, like the long term goal of getting a car isn't important to the family who puts their kids first and thinks a gift for the kids is more important.

Anna: Yeah.

James picks up on the term "*Koori time"* and considers how it is used by some white practitioners disrespectfully. In some practices, if an Indigenous person is late or doesn't attend an arranged appointment, the term "*Koori time"* may be used by a practitioner in a derogatory way to undervalue their absence. Use of this term privileges white practitioners' ways of understanding Indigenous peoples who are seen as different or other, allowing for them to be understood as inferior, irrelevant and therefore marginalised (Boreus, 2006). James recognises this marginalisation, and resists a narrative of his Indigenous clients' perceptions of time as irrelevant. Again, James's actions are consistent with him acknowledging white practitioners privileged status over Indigenous peoples, so that it might be addressed and 'undone' (Pease, 2010).

8.9 "I'm feeling really suicidal, I really need some help"

Much later in same conversation, the group shares further stories of working with Indigenous clients and their families. I have previously worked professionally with Daisy, James and Anna in my role as a child adolescent and mental health practitioner, based in their region. Part of this role included developing partnerships with groups at a high risk of suicide, such as clients of my participants and a local Indigenous co-operative, so that I could provide mental health services to these communities. I share a story of a barrier I encountered while establishing these connections. Anna then joins me in telling her story of not being able to provide services to an Indigenous woman client because of her agency rules about contact with clients outside of office based locations. She also adds the issue of gender to our group discussions of intersectionality issues. These stories add a dimension of further social injustice, in the form of the inaccessibility of services to marginalised

clients and families. The people Anna and I speak of are already disadvantaged, facing considerable risks of suicide and domestic violence. Domestic violence is a significant health issue for all women and children, however Indigenous families are one of the most at risk populations (Department of Human Services, 2012). Our stories highlight the extensive vulnerabilities of this group, and how our group advocated for them within our professional roles.

> Annette: *Yeah, I'm just thinking that the Indigenous people that I've worked with here, when I worked for* [name of mental health service] *and in private practice* [family therapy]. *I've had some Indigenous people come to see me, kids and families. Um it's a longevity thing, you know making connections with them. And they suss you out you know, and that takes a long, long time whether you are a trustworthy, white person or not. Um and our systems, I'm thinking particularly health systems because that is what I know, are so inaccessible and unhelpful. And an example would be um, and I'm talking particularly for Indigenous clients but for young people to and from other cultures too as we have other migrant groups too.*
>
> James: *Yes*.
>
> Annette: *They ring up our crisis line, you know*. [A] *young person or family member rings up and says, and they were from K* [the focus groups agency] *which reminded me of them. They rang up and said, "I'm feeling really suicidal, I really need some help". And for a young person to actually do that it is so huge.*
>
> Anna: *Yeah*.
>
> Annette: *They don't usually ask for help so I'm thinking gee this is huge.*
>
> James: *Yep*.
>
> Annette: *I didn't know about this until it was presented at a team meeting. And there was discussion about how it was going to be dealt with. And the intake worker said that's lovely*, [to the client ringing in], "*Can I take your name" and whatever, as they do because we have forms to fill out. Because forms are really important* (I say this with sarcasm).

Anna: *Mmm*.

James: *Mmm, it's called formal register* (from Bridges out of Poverty Training).

Annette: *Excuse me* (I cough). *So we fill out some forms and then* [the intake worker says] "*You'll have to come into the office for an assessment*". *And of course, as you can imagine, a young person's reply to that.*

James: *Mmm of course, definitely* (James says this with humour, while smiling).

Annette: [And the young person says] "Of *course I'll race to be there, apart from the fact I've got no public transport and whatever*" (I say this with humour). *And they said*, "*Well I can't come in*". *And the response from the* [intake] *worker, who shall remain nameless was, "Well you obviously don't have a problem. If you can't come in to access our service you obviously don't have a problem". And um, that was bought forward and presented and I'm bit like you* (I say this to the group). *I was appalled when I heard that a young person had rung for help, immediately my response was, particularly with mental health issues that's a major thing they really need help or they wouldn't be ringing. Um secondly they are open about what they want help for and they are asking for it, and you won't go and see them. And that's about the inability of the system to adjust, to the young person, or the Indigenous community. The barriers are so high to even get access in the first place*.

James: *That's right and they'll hang up the phone and say*, "*Those mongrels won't come, they won't do anything for me, they're useless*". *And they are quite right from where they are coming from, you know. On the other end of the phone, "Well I offered him help but he didn't accept it". And what's going on, how simple is that to fix that, how simple should that be. That's exactly yesterday,* [in the training]. *Formal register versus that other register that I can't remember, the casual register? But that's not what they want to hear. And it's not what you want to hear. And you refuse to hear each other, so nothing happens and um very, very hard.*

This story highlights once again the collision of intersectionality issues of differences of race, culture, class and gender (for our female clients). Young mentally ill adolescents are oppressed and marginalised when they fail to conform to rules of predominantly Westernised health systems. For example, having to attend office based appointment to receive service. They are marginalised because of their status as Indigenous, poor young people. In addition, those clients who are female also experience further oppression because of their gender.

8.10 “Meet me at the river”

Later in our same focus group conversation as it ends.

> Anna: *It happens in other forms as well, in K’s and rightfully so, we have some very strict rules around how you work with people. And I had an Indigenous lady who came to me, she would just pop in. This is for family violence counselling, she would just pop in. You would make an appointment, she wouldn’t show. But then she might come up the next day and say, “Oh I didn’t make the appointment”. She knew she’d missed it and [she said] “Ah, can I see you now?” But, it quite often dawned on me that, that if I could have just gone to where she was or just said, “Meet me at the river”, or something like that, um it would have been so much easier. But we are not able to do that because of worker safety. Sometimes it, suppose it really for me it would have been good to be able to do that because I would have been able to have gotten a lot, worked a lot better* [therapeutically]*, with her yeah.*
>
> James: *That’s right, yeah.*

The practical result of the policy of Anna’s organisation was that her client received no service or counselling support for dealing with sensitive issues of domestic violence. She was disadvantaged on numerous levels, consistent with theoretical foregroundings of intersectionality issues (Davis, 2008; Valentine 2007). For example, she was disadvantaged for being racially and culturally different as an Indigenous person; disadvantaged because of her gender as a woman; disadvantaged because of her lower-socio-economic position as a poor person and finally she was further disadvantaged because of her rurality, meaning geographical and social isolation and limited access to health and social support services. Anna’s

“Meet me at the river” story highlights issues of social injustice and the almost incomprehensible exclusion of a woman from services vital to her and her family’s social and emotional wellbeing.

Anna herself was also impacted upon as a practitioner. She was unable to connect with her client to offer counselling support, and this did not fit with her, or the focus group’s declared social justice agenda. We witnessed her distress during the telling of this story in our group, and it speaks volumes that this story has lingered with her long after it occurred because of the injustices involved. We are all left wondering if this woman and her family survived, haunted by the idea that they might not have, and what this might mean to our identity as socially just practitioners.
Our Gippsland focus group stories in this chapter include examples of our everyday practice altercations with issues of intersectionality. These stories illustrate the interconnectedness of these issues, and the devastating impact they have upon the lives of our clients and their families. These stories detail my participants and my own professional practices, and reflections upon these same practices from our therapeutic work with intersectionality issues.

Differences of culture, race, class, rurality and gender created multiple complexities for us as rural family therapists. Working to create an ethical and socially just understanding of intersectionality issues within these spaces is a complex task. James, Daisy Anna and I offer glimpses of ourselves as socially just practitioners, struggling to do so. I offer our stories here to other rural health professionals also struggling to practice as socially just practitioners. My purpose in doing so is deliberate as part of a process of ‘undoing’ our privilege (Pease, 2010) as white Westernised, middle class professionals working with Indigenous families. My hope is that that our focus group stories will challenge, enrich and inform rural professional’s practices for the ultimate benefit of the Indigenous families we serve.

8.11. A problematised Indigenous people’s history

To further understand the difficulties our focus group faced in taking up socially just practices in our work with clients, I deconstruct our stories of grappling with issues of intersectionality using Foucault’s concept of problemisation (Neal, 2009). My use of a

problematised history is consistent with Australian Indigenous author Moreton-Robinson's call for white practitioners to understand our own intentions, and position of white privilege and power, which is not always visible. She comments, "white people's actions may be driven by compassion and good intentions, but the discourses and power of whiteness underlying this compassion and these intentions may not be seen" (Moreton-Robinson 2000, cited in M.Green and Sonn, 2005, p. 487). This layer of my analysis reveals underlying issues of power and resistance within our Australian history of the ongoing colonisation of Indigenous peoples. I come to understand our position as white Westernised practitioners, working with marginalised and oppressed families, as being located within wider sociopolitical and historical contexts. My analysis is consistent with social constructionist theory which recognises how we, and our clients, are embedded within such contexts (Burr, 2003; Gergen & Gergen, 2008a, 2008b).

In explaining Foucault's concept of problemisation, Neal (2009, p. 167) proposes that "Foucault looks at problematizations [sic] in history ... [He] asks how ... [a problem] became a problem historically ... considering social, political and historical thought". My own use of a problematised understanding of an Australian history reveals the ongoing colonisation of Indigenous peoples (M.Green & Sonn, 2005; Smith, 1999; Young & Zubrzycki, 2011). Enfolded in this history are events such as the forced removal of Indigenous children from their families nationally, and the local massacre of Gippsland's Indigenous peoples (Eckermann et al., 2006; Gardner, 1983; Moreton-Robinson, 2000; Pepper & De Araugo, 1985; Young & Zubrzycki, 2011). Sections of the text which outlines this local massacre begin this chapter, as an acknowledgement of the tragedy of this event.

Westernised white knowledges were privileged over Indigenous peoples' knowledges during and since colonisation (Bennett et al., 2013; Green & Sonn, 2005; L. Smith, 1999; Young & Zubrzycki, 2011). A powerful example of this privileging was in the naming of Australian land as "*terra nullius*" (Eckermann et al., 2006, p. 5, italics as in original) by European explorer Captain Cook. This term implied that the Australian land was "Uninhabited ... an empty continent ... because Aboriginal [Indigenous] people failed in the invaders' [colonisers'] eyes, to use the land" (Eckermann et al., 2006, pp. 5-6). During colonisation European explorers

deemed communities to be ‘civilised’ if they had a recognised leader and managed their land in Westernised terms, such as by the farming of land and animals (Bennett et al., 2013, p. 4).

The colonisation of Australian Indigenous peoples continues to impact upon Indigenous health and wellbeing in current times. For example, Indigenous peoples in rural areas have less access to health services, dying 12-17 years earlier than other Australians (Australian Institute for Health and Welfare [AIHW], 2012a; Gregory, 2010).

My use of a problematised Indigenous people’s history in my analysis makes visible issues of power, privilege and oppression between Indigenous people and non-Indigenous white peoples, as part of an ongoing colonisation process. This problematised history locates us, as Gippsland focus group members and our Indigenous families, within wider sociopolitical and historical contexts as we struggle with intersectionality issues together. We are not alone in these struggles, they exist in other national and international contexts which I now explore.

8.12 National and International perspectives of the colonisation of Indigenous peoples

Educational researcher Susanne Gannon (2010) writes of her experiences as a white teacher of Aboriginal students within an Australian context. She explores how race is “associated with differences of language, knowledge, gestures, bodily practices, and degrees of privilege and disadvantage” (Gannon, 2010, p. 71). Her accounts provide intimate details of her work with Aboriginal children where “the degree of deprivation astounds her ... only the girls are provided with shampoo and conditioner” to wash their hair” (Gannon, 2010, p. 81), while one male student has head lice falling upon his book, distracting him from learning. Gannon’s (2010, p. 71) task becomes “to complicate understandings of what is ethically and educationally at stake in theorising difference”. This allows her movement towards engaging and learning *from* and *with* her Aboriginal children rather than following traditional teaching methods of teaching *to* students. Gannon’s embodied work gives readers access to understandings of issues faced by a white practitioner working with

Aboriginal students. She offers a deeply personal view of the challenges she faced in her accounts of cultural differences between herself and students.

Reading Gannon's work I am transported into the classroom with her as she grapples to find new ways of working with her students across these differences. The immediacy of her story connected with my own daughter's teaching of Indigenous children and young people while I undertook this study. My daughter's struggles for social justice for her students also became mine, between the tears and distress we shared during her long distance phone calls home together.

From an American perspective Denzin (2003, p. 311) writes of his "search for meanings, for answers" in relation to understanding "the Empire's colonization of Native Americans; a violent exercise in political, cultural, sexual, and economic power" (Denzin, 2007, p. 298). Denzin (2007, p. 298) suggests we "rethink" an historical view of Native Americans as an inferior population where "this ideology directed [explorers] Lewis and Clark to kill those Native Americans who did not help the expedition to attain its goals". The Empire's aim to kill selected Native Americans was partly achieved by deliberately giving them blankets, branded as Hudson Bay blankets after the company which produced them, which were known to be infected with smallpox disease (Denzin, 2007). Denzin's narratives provide unique ways of re-examining the historical treatment of Native Americans, alongside current ideologies of understanding the cultural and racial differences of Indigenous peoples. I consider his work challenging to white readers. It provokes exploration of how descendants of white colonising nations are themselves embedded within historical and current contexts in relation to the marginalisation of Indigenous peoples.

From the United Kingdom, Burman (2005) argues for the importance of considering issues of culture and gender together, rather than privileging one over the other, in psychotherapy practices. She suggests that, "matters indicate the impossibility of disaggregating gender and culture, alongside the impossibility of analysing gender outside culture" (Burman, 2005, p. 543). Alongside issues of gender and culture Burman also highlights the importance of relationships of power within psychotherapy which have often been unacknowledged. She proposes that practitioners consider how the dynamics of power, race and gender are played out in

therapy and how these might be used as a resource within therapeutic practices. This is a particularly useful perspective for practitioners moving us into a space of considering the usefulness of these intersecting issues, which inform therapy practices rather than viewing these issues solely as barriers to be overcome within family therapy practices and theory.

Gannon (2010), Denzin (2003, 2007) and Burman (2005) reflect both national and international perspectives of others, like my Gippsland participants and me, struggling to present ethical accounts of working across issues of cultural, racial, gender and power differences. If, as Gippsland focus group members, we consider aligning ourselves with others seeking social justice within these broader national and international contexts, we create opportunities for alliances to challenge oppression, as called for by Roberts and Jesudason (2013). In addition, we are offered theoretical and practical guidance in dealing with difference within an intersectionality framework.

8.13 Chapter summary

This chapter has presented issues of Gippsland participants and I working with differences of race, culture, class, rurality and gender. I have described these issues as ones of intersectionality to underline the significance of their interconnectedness and impact upon our professional practices, and lives of the families we work.

Issues of power, privilege and oppression between Indigenous and Non-Indigenous, white people are ongoing issues of concern to socially just practitioners. Given the complexities of intersectionality issues, located within these wider sociopolitical and historical contexts, it is understandable that James, myself and other focus group members struggled to deal with these issues with our clients. For example, James' therapeutic work was challenged by his attending The Bridges Out of Poverty training, and reflecting on the generational poverty framework for understanding class that was offered to him. This framework suggests that issues of class are produced within social and historical contexts, resulting in complex influences upon disadvantaged families (Payne et al., 2001).

James had previously considered issues of class structures as challenging to his practice. Taking up a new generational poverty framework allowed James to transform his own understanding of how class issues were produced historically, and expressed currently in disadvantaged families. His task became one not of facing challenges to his practice posed by the families themselves, but to face and understand issues of class imposed on these families by predominately westernised health and social services, and expressed in their everyday differences of knowledge, language and behaviour (The BBQ story, and working class background story).

However, this generational poverty framework was not helpful to James in all of his therapeutic work with clients. For example, he was unable to understand why a Koori man would rather die than be disconnected from his Indigenous heritage. This framework did not include theoretical understandings of other issues of intersectionality, such as gender cultural and rural differences, or the complexities created by the alliance of such issues. It was therefore difficult for him to utilise this framework to conceptualise how racial and cultural differences compounded issues of class, in his 'buying a bird' story. A generational poverty framework lacks the more complex understandings of difference offered by intersectionality theory. For example, even within already privileged positions, such as class structures, subtle hierarchies exist (Pease, 2010). An example of these is Anna's and James' story of the 'Titanic', and sub-categories of '*new money'* and '*old money'* within hierarchies of '*high'* or upper class.

While a generational poverty framework offered James and Anna some guidance in understanding issues of class differences, it was itself embedded within histories of the ongoing colonisation of Indigenous peoples, locally and internationally. From James' own understanding, this framework did not address these significant cultural aspects of difference, power or privilege in his work with Indigenous families. Intersectionality theory offers rural practitioners a more far-reaching and sophisticated understanding of difference than a generational poverty framework, and is worth embracing for the subtleties it offers us in our practices.

Pease (2010) offers useful insights for how we might address issues of privilege as white practitioners. He suggests firstly, that white people must first acknowledge that we are white. Secondly, "…white people must come to understand that what we do in the world reproduces our privileges" (p.127). Thirdly, work to change systems that support and finally to, "…challenge the invisibility of whiteness as normative" (p. 127). Our Gippsland focus group narratives reflect our struggles with issues of intersectionality and involvement in each of these steps Pease (2010) describes. Pease's (2010) suggestions are useful ones for other rural family therapists and practitioners to consider, in being socially just in our therapeutic work with Indigenous families.

Chapter Nine

Multiple relationships in rural communities

The question is never this *or* that, but always this *and* that (Deleuze cited in Wyatt, Gale, Gannon, & Davies, 2011, p.2. Italics as in original).

9.1 Introduction

The ethical complexities of multiple relationships introduced in my literature review are a significant part of stories told by my participants and me in this chapter. Discussions by Eleni and me of the frequency of multiple relationships we experience within small rural communities were echoed by all my participants. The stories of Eleni, Alana, Julia, Mark, Jacqueline, Anna and me are representative of the experiences of all of my participants and offer examples of multiple relationships for rural family therapists and the ethical complexities these relationships have created for us professionally and personally.

Michel Foucault (1980; 1982; 2000) and Jacques Derrida (1982) have remained as my dinner party guests. I now invite them to join me in discussing participants' stories in this chapter in my next layer of analysis. We talk together about how my participants and I understand our multiple relationships and associated ethical issues within our family therapy practices. Derrida (1982) continues to offer me guidance in deconstructing our narratives of rurality. My participant, Jacqueline is familiar with Foucault's (1980) influences within narrative therapy (White & Epston, 1990; White, 2007) and calls upon these in her story. I discuss with Foucault (1980), using my own understandings of his concepts of power and resistance, to further analyse Jacqueline's story of the process of subjectification of one of her students involved in a "*breach of ethics"*. Her conceptualisation of this student's dilemma, and my further analysis of this, offers an alternative and important way of understanding multiple relationships within rural communities that is constructive for family therapists.

These stories deepen understandings of rurality as relational and complex through our discussions of how we manage multiple relationships in our everyday practices. Firstly, narratives of Eleni, Mark, myself and my Tasmanian participants introduce

alternative understandings of our multiple relationships with our rural clients and communities, and the complexities of maintaining confidentiality and ethical boundaries within these relationships. These understandings counter dominant urban based understandings of rural family therapy practices as unethical when relational boundaries blur between therapists and clients. Secondly, Anna's story of being a bushfire counsellor following the Black Saturday Gippsland bushfires in 2009, introduces readers to the impact of these events upon local practitioners and significant issues of secondary traumatic stress for them. Lastly, Jacqueline's narrative discusses her experiences of teaching rural family therapy training and her conceptualisation of the marginalisation of rural understandings of confidentiality and multiple relationships.

A final layer of understandings of the complexities of multiple rural relationships is added to the counter-narrative of understanding rurality as relational, that has emerged throughout my results chapters. Nuances within the complexities of multiple rural relationships are highlighted as a resource for clients, communities and therapists as an important part of the relationality that exist within rurality.

9.2 Eleni: "I'll put you in good hands"

I first spoke to Eleni, as the main contact person of the then Victorian/New South Wales Border Family Therapy Interest Group (BFTIG), to ask if any of these members might be potential participants within my study. We spoke by phone a number of times over a twelve month period as part of my approved PAR approach. I then flew to meet with Eleni and other potential participants to introduce this study to them, and develop a research relationship consistent with feminist research principles (Olesen, 2005; Reinharz, 1992). Unfortunately the BFTIG group disbanded after this meeting and Eleni and I discussed what to do. She remained interested in being a participant. However, given the geographical distances between us and costs involved for me travelling to meet her again, we decided to do her individual interview by phone. Eleni was the only participant with whom I had a phone interview. In the spirit of rural hospitality, Eleni had invited me to stay with her and her family when I travelled to meet with her in person initially. During this time together we came to know each other as colleagues, creating a context of

relationality we called upon during our phone interview. My approach in having a phone interview with Eleni acknowledged rurality as relational, while adapting to the practicalities of local rural contexts. This is consistent with a PAR approach (Reason & Bradbury, 2008).

> Annette: *The other thing that was on my mind , I worked to late last night so I didn't start thinking clearly until this morning I have to say*. (I laugh and Eleni joins me in recognition of our commitment to late night study as therapists). *Um, I was driving into* [my work location] *and I was thinking about the interview with you. And I was thinking about the conversations we had in the car* [when I travelled to meet with Eleni initially] *with the gorgeous* [Eleni's baby's name].
>
> Annette: *And um, I don't know whether you want to discuss it or not, but I just wanted to raise it. It was interesting we had a conversation around the difference of ethics* [in rural settings].
>
> Annette: *You know, understanding relationships with our clients and our families and communities. And I did not know whether that was something that was just a conversation for then or whether that's something that was interesting enough to talk about now. If that's part of rural family therapy*?
>
> Eleni: *Yeah. I guess so. I mean I'm not really sure. I think for me ethics are something they can be quite black and white on one hand. But there are certain things that are ethical, and that's how it needs to be no matter if you are in a rural setting or a city setting. But I guess a level of professionalism that um, that just has to be upheld. But I also think there can be some grey areas that are more obvious in a rural setting. And I guess that's around um, you know, there is only so many, so many people that live in a small areas and you are bound to come across them in different settings and how do you, you know, do you tackle that? Yeah and I'm just trying to think of any um examples really. I guess just bumping into clients outside of the professional setting and how do you manage that? Yeah I mean for example, I've got a um in one class at* [name of university where she teaches family therapy] *I've got an ex-client, the daughter of an ex client and a young woman who is seeing*

my sister as a client [who is also a therapist]. *That's in* <u>*one class*</u> (Eleni says the underlined words with emphasis). T*hat would well actually scare the pants of* [non-rural therapists]. *And you do* [manage it] *and it works out fine, you know. Initially it seems like it could be such an enormous issue. But it's kind of when you break it down and actually do it, it's not. Yeah and you can be quite clear about how you manage such situations and what is work and what is study and yeah.*

Annette: *Yeah we have had a similar conversation in another* [research] *group I ran*. *The issue of ethics came up for them big time because they had very similar issues*. *And again they said similar things, different words.* [For example*] there are some things that are um a total given, sleeping with clients, sexual abuse that's an absolute professional no no and that's a given.*

Eleni: *Absolutely* (Says this in firm tone to agree).

Annette: *But that greyness that you talk about around relationships. That in fact we are really well known in our community. We do run into friends, neighbours* [and] *colleagues* [outside professional consultations]. *It happens and the um, other thing that came up that I thought was interesting, was the discussion about, and I'm interested whether you've been finding this in your practice, that it's actually through people who know us that we get our referrals.*

Eleni: *Yeah*

Annette: *Which I think is fascinating. It's not just um, the people reading you online or seeing you in advertising.*

Eleni: *For sure*.

Annette: *Like I got referral from a colleague who sent their daughter, then their daughter knows someone else. Or um, when* [I was] *in another area a school counsellor knew me really well and she had close friends having issues* [so referred them to me and they travelled some distance to meet]. *So it's that being known and another practitioner talked about that as well.*

Something to do with being trusted and having respect and once you gain that in you region …

Eleni: *Yeah*.

Annette: *People refer. I found that interesting. It is almost the flip side to the ethics* [of professional bodies]. *It is not just about the boundaries of keeping distance* [from our clients]. *Um, there's something about the relationships in rural that are a little bit different*? (I say this in an enquiring tone to Eleni to elicit her thoughts on this topic).

Eleni: *For sure. I find a lot of people, a lot of my sort of first layer of friends who obviously wouldn't choose to come and see me because they're friends* (Eleni laughs). *But they will often ask me to recommend someone else and I think it is that um absolutely, that trust. That if you know someone and think, I think they're ok then I'll take your word for it. That almost giving them you know, "I'll put you in good hands" kind of thing. This person will be professional and good for you and offer you what you are after. Um, and I guess the same with you now with that. You know, next layer of connections that would come and see me because they know a friend of mine or they have heard about me via someone else. Or they have meet me in a fairly distant context, yeah.*

Annette: *Yeah*

Rurality in Eleni's narrative adds depth and wisdom to understandings of rurality as relational, and the complexities of multiple relationships for family therapists within this. Eleni manages the complexity of these relationships by unravelling the layers of each relationship, relative to ethical considerations for her as a therapist. Her strategy of "*breaking down*" each layer of relationship, allows her to separate out roles for herself and her students to be addressed individually. For example, complexities of previous client-therapist relationships in her classroom are part of her "work" role, while complexities of her students' connections to her own family member are part of her "study" or tutor role. A layering approach to addressing complex ethical considerations in rural contexts, makes transparent the intricacies of

each connection, allowing these to be attended to as part of an overall holistic approach to confidentiality. Elena's story offers an important insight into a practitioner's everyday ethical dilemmas, while providing an astute conceptual framework to address these concerns. Given this, Eleni's strategy offers a useful guide for other rural family therapists in addressing relational complexities in a considered and ethical way.

9.3 Mark. "How do you keep your boundaries"?

Like Eleni, Mark has complex and multiple relationships to his clients and community. Given his long career as a family therapist, over 40 years, these relationships are extensive, influencing all aspects of his practice. Mark and I have been discussing the topic of ethics. I explain this has been a theme in my interview with other therapists to invite him into further discussing this topic.

> Annette: *So those kind of issues have come up as well and there's been lots of discussions about um, ethics as well*.
>
> Mark: *So how do you keep your boundaries?*
>
> Annette: *Yeah even the notion of boundaries. And the fact that many people um, come for service, come to see family therapists who are still working because there is nowhere else for them to go. The distances are so vast to get down to* [name of city] *for one of them, they can't afford it. Some of them don't have transport you know a lot of the families we see are in, in having really tough times so* …
>
> Mark: *I remember too, some of them say walking down the main street they meet in the small town. They met* [clients] *they know. And how do you deal with the fact you know all their secrets as you are buying a milkshake with them at the counter? And um, I think those things are very natural things to happen. But um, I think when you are learning about boundaries they are quite real for them to, so ah um* …
>
> Annette: *That was an interesting topic people talked about as well. Like managing that. But also the other side of the issue was the number of people*

that come [to therapy] *because they are referred by people who know them, rather than just anonymous referrals that they come through word of mouth …*

Mark: *Oh yes*.

Annette: *Like I may see, well I'm seeing a family and they'll send the sister and then they have got friends who'll send a couple and it's like a rippling effect*

Mark*: Yeah, it is too.*

Annette: *And some people* [therapists] *said, "Oh we wonder about that, are you supposed to see people that you know*"?

Mark: *Well I think that that bit of ethics I would have serious questions about. Where they get too strict with boundaries. And one of my difficulties is I've been in this* [name of city] *area for 40 years. And I work in the* [name of place in city] *a lot. And it's impossible for me to go anywhere because I'm well known in the* [name of place] *without meeting clients all over the place. And I think that um the actual strict ruling in ethics somewhere, I think it is in PACFA* [Psychotherapy and Counselling Federation of Australia] *is that you should not um help someone whom you've had any contact with at all before. Now in my work I'd have to close my practice basically because a lot of the people I see I know, or half know someone who knows them*. [I] *might have met them somewhere and it works fine. I think the issue is to be clear on what the issues are. So you know, I've worked with the daughter of a very good friend of mine and her marriage. Now I knew the daughter well I didn't know the husband much at all, so we sat down and they said we want to go to* [Mark] *and that's it. So they came. So we talked about how we would cope with the fact that I knew the lady but didn't know the man at all. And how did he feel being there and the fact that I did know his wife. He said that made it ok for him to be here, the fact that it was bought out. So I imagine the same thing with rural people, which could happen a lot more um [because of close] boundaries there would be in small towns.*

Annette: *Very, very large issues which were discussed. And I find it interesting that you, you travel* [to] *rural* [regions to teach family therapy] *and you come*

back to this [his practice location] *as an urban community because you are metro really. And if you notice any other differences* [between the two locations]. *Because that was something that was very obvious to me straight away when I shifted from an urban up to working rurally. The issue about boundaries and ethics became very large, very large.*

Mark: *Mmm.*

Annette: *And it's interesting for us, as part of this research, that some people have spoken about that it's been a real issue for them. And they haven't been able to speak about it because they feel as though the professional guidelines have really bound them up.*

Mark: *Right, yeah*.

Annette: *They* [professional guidelines] *say, you know, we are not to have dual or multiple relationships is what is says. But in fact we have to see the clients, there's no-one else that would, will see* [some of our] *the clients*.

Mark: *And even if there was they might have the right to* …

Annette: *Yes*. (I say this with strong emphasis to agree with Mark, as he speaks).

Mark: C*hose the person they want. And I can see the point of the rules. But also I can see the necessity of um, being able to operate outside* [the rules] *and provided everything is clear and there's no actual violation of ethics.*

Annette: *Yes*.

Mark: *In terms of people not getting the right service that they deserve, which I presume is the point of …*

Annette: *Yes and they* [colleagues who have spoken of this issue] *are very, very clear. Very ethical people with all those considerations* [Mark has cited]. *And all the thoughtfulness has gone into it. But that's just one of the issues that particularly in rural has come up.*

Mark: *Yes*.

This story is an example of a co-created narrative by Mark and myself, which adds a further layer of understanding to the complexities of multiple relationships for rural family therapists. Mark highlights the rights of clients to choose who they wish to have as their therapists, foregrounding their needs. Relationality in a rural context is an important part of how clients chose their therapists in small communities. This rural relationality contradicts dominant professional ethical guidelines, many of which mandate no therapy with those who are previously known to therapists personally. Mark's narrative challenges this dominant narrative of rural family therapy practice as unethical. His story further strengthens a counter-narrative of rurality as deeply relational, adding his practical understandings of managing therapeutic boundaries within multiple rural relationships.

9.4 Tasmanian participants and confidentiality "When I see you in the street do you want me to acknowledge you?"

The theme of connectedness within small rural communities is evident within my research conversation with my Tasmanian group participants (Julia, Audrey, Alana, Angel and Kitty). Like Eleni and Mark they have identified how clients are referred to us as family therapists because of our previous relationships within our own communities, and the complex issues of confidentiality related to this. Alana has raised the importance of these aspects of our practice which she explains:

> Alana: *And the confidentiality* [of living in a small rural community as a family therapists].
>
> Julia: *It's huge* (Said with emphasis to support Alana's statement).
>
> Alana: *It's huge and as a pressure, my memory is not getting any better* (She laughs). *And one of the things I say to the clients I work with um, families and clients that I work with um, is that whilst we are working together I consider that we are working as a family. And if we do have individual sessions and individual time I will ask you, "Is there anything you specifically don't want me to say to the others? But everything else may come up, so please be warned if you don't want me to share." And, "If there's something between us that you think, at this stage you don't want me to share with mum"* [tell me]. *If I'm*

talking with the child, I will try and honour that um. But the other thing about confidentiality is that most people they'll say things like, when I'm filling out all the [consent] *forms, I'm very clear with the confidentially, about what can and can't be taken from that room and the exceptions etc. etc. But I think it's really important in a small place like* [name of her town] *where I come from. Because I walk down the street and I also ask them* [her clients] *"When I see you in the street do you want me to acknowledge you?" or, "Do you want me to* [acknowledge you], *if you see me in the supermarket? "I'm ok with whatever you feel comfortable with, but please let me know now so that it doesn't create a situation for you. It won't for me because I'll say hello if that's, if that's ok with you" But um, because I just see somebody's face that I recognise, once again the memory thing.*

Alana says this with humour at her own ability to remember.

Alana*: I'll smile because I know a face, may not remember the name. But if it's someone who has specifically asked* [to not be acknowledged]. [I] *think it's much easier to take control of that, "Well she* [Alana] *is really serious", rather than me just, you know walking past them in the supermarket and either ignoring them, because they don't want to be acknowledged. Hang on, there are also people who know me in the supermarket, know what I do for a living. So oh they* [her clients think, others also] *have been seeing Alana. People who I'm talking to,* [I] *will see someone in my peripheral vision and I'll go like that.*

Alana turns her head to indicate looking at someone in recognition.

Alana*: Or something like that and the other one* [client who she is talking to at the time] *says "Oh who is that*? (Laughs) "*How do you know them"? You know so it's at that level whereas I don't imagine in bigger cities it would be like that but it may be I don't know.*

Annette: *Some people, other people* [research participants] *have talked about similar things. Depending on the size of your city and connections to the community. If you have a larger city* [less likely to happen] *but if you have a small community, some of the different cultural groups*…

Julia: *Within that*.

Annette: *Yeah that could be true but I tend to think that um, for us, that it's far more common in smaller towns.*

Group: *Yes* (said with firm communal agreement).

Annette: *Certainly more common for me and everyone else I work with in our region.*

Alana: Yeah, *definitely. That referral thing you were talking about* [previously] *Annette. That people say*," *I'll go and see Annette because you know she helped my cousin twice removed and she was great". So there's a network out there that talk to each other when there, you know when the chips are down or there's a problem. Or little Johnny's* [fictitious name] *misbehaving. Usually some* [clients] *will be able to say "I went to so and so and they were good". Or "I didn't like them, don't go there for heaven sake". So there's that verbal level* [of communication] …

Julia: *Which is another pressure isn't it*? *Because If you're a um, you know. And the reality is that relationships is not always easy to join with every person who walks through the door. But it's because I sometimes worry about that expectation. When people come in and they've said "You know so and so said you were fantastic". You know, because you think wow if that [therapy] just doesn't happen to work for some reason …*

Annette: *We are in big trouble here* (Said with humour).

The Group all laughs together, recognising as therapists the huge and unrealistic expectation on us to engage with all our clients in therapy.

Alana and I agree with other participants Eleni and Mark that we often have referrals to us as therapists because we are known, accepted and respected within in our own small communities. We understand these relationships within rurality as helpful, and part of an informal networking system. However not all participants experience this community acceptance as helpful. Julia's narrative describes her reflections on how her "*connection*" to her small rural community both helps and hinders her personally

and professionally. For Julia her acceptance as a therapist in her community created a "*pressure*" and an increased "*expectation*" to engage and help everyone referred to her, which was unrealistic. Her story raises the important point of how rural family therapists deal with being the only therapeutic resource in some locations. Therapists in this situation are placed in a difficult and ethically complex dilemma. In a later conversation outside this interview, Julia and I spoke of the reflective questions she began asking herself in relation to this ethical dilemma. These questions included, What would it mean for her if she was not able to help a client referred by her own family or friends? Would her family and friends think less of her as a therapist if this occurred? What might the impact of this be on her own level of professional confidence? Further, what are the professional implications for her as a therapist if she is unable to help clients referred to her? Would she continue to be accepted within her own community? While these questions potentially raise more complexities, they are useful considerations for other sole practitioners to reflect on in understanding the impact of the multiple relationships for rural practitioners in small rural communities. In pondering these questions answers may arise over time that are helpful in addressing these ethical complexities. I have included them here for their potential usefulness for rural practitioners during supervision of their therapy practices.

9.5 Anna: "I can't do this anymore"

Gippsland focus group participants Anna, James and Daisy discuss their roles of supporting clients and communities affected by the Black Saturday Gippsland bushfires in 2009. At this time, Anna left the organisation she had worked for with James and Daisy for some years and was employed as a bushfire counsellor by the local shire. This new role became very complex for her because of the multiple relationships she had with these clients and her own traumatic experiences of these bushfire events.

> Anna: *We were talking about* [name of client] *at the last team meeting. Saying how difficult* [it is] *for us now because we are working with a different type of client group. Originally we had both* [been] *working with a low socio-economic client base, mostly, and to move from that into the type of client base where it could, you could easily be* [Seeing] *friends, easily be family members you*

know that, the same how do you, it's really hard to put it without being derogatory (Anna laughs). *But it's made it harder for me to go home because um,* (Pauses to think for four seconds). *I don't know why actually, it's made it harder for me to go home because you've got what's going on for them* [Bushfire affected clients] *in your mind. Thinking this could easily be me, this could happen to me. There's no, um I suppose, in some strange form I don't see myself as ever being able to get to the degree of maybe the circumstances where people have drug or alcohol issues because I am so wary and so, that's over there I'm never going there whereas for a bushfire affected person, that's something that could very easily happen to me.*

James: *Mmm, when you are looking at the bushfire issue…yeah*

Anna: *So it's got this personal aspect.*

Annette: *That's interesting, is this the shire* [Council] *work, particularly since you have been doing bushfire* [counselling] *work*?

Anna: *Yeah, that's part of it. Um, I have also been doing some work with the community recovery group and um, I've got people that I have been friends with in the past and whatever coming into those groups and discussing it* [The fires]. *That's not necessarily people that have had fire come to their doorstep, it's for anybody that's been impacted in any way. And you can basically say the whole of* [name of her local town] *and district has been impacted in some way. So um, yeah it's that part of it is quite difficult. And I got to the point where I did say to them, I can't do this anymore. You need to get somebody else to come in and do this group. So it took them two months to advertise* (Anna laughs, while looking very thoughtful as she says this. I see on the DVD of this interview she has mixed emotions).

Annette: *I think I know what you mean. You couldn't do that role anymore because of the relationships, you were so close to the people, they were friends and neighbours and things like* that? (I say this to Anna in an enquiring tone of voice to check with her I have the correct meaning of her previous statement).

Anna: *Um*.

Annette: *Is that what you were meaning, or*? (Again, I say this in an enquiring tone to Anna).

Anna: (Pause for three seconds while she thinks, before responding to my question).*The people that came there, it could very easily have been someone very close to me that walked through the door. But the people that came there I hadn't been close to. But I have known for years, um. Some of them like, since I was knee-high to a grasshopper* (She laughs at her memories of this) *basically and that was challenging for me as a person*.

James: *Mmm* (James looks at Anna and murmurs this in agreement with her statement).

In our final focus group meeting three months later, I asked the group to reflect on our research meeting times together, and if anything stood out for them as important from these conversations. In the context of reflecting on her bushfire counselling role, Anna made the following comment:

Anna: *Well, it took me probably three months maybe longer, for me to realise that I had moved into this helping role but I probably needed to be helped myself.*

Following the Black Saturday Gippsland bushfires, health professionals were appointed as part of a government funded initiative to provide counselling and support to those affected by these events (State Government of Victoria, 2009). Anna took up one of these roles, which bought new meaning to her previously established and workable relationships within these communities. Her bushfire counselling role became complex. She was required to support a number of communities affected by these fires, including her own local town. She recognised the potential for her to be involved professionally with people known to her personally, as bushfire affected clients. In addition, she identified quickly with these clients leading her to recognise her own vulnerability in relation to experiencing bushfire trauma. Her reflective practices as a family therapist, highlighted for her that as she was counselling others in her community as a professional, she herself had

also been traumatised personally by the bushfires she experienced. Eventually Anna removed herself from one aspect of her counselling role that of facilitating a group made up from bushfire affected community members. In removing herself from this group, Anna created space between herself and those she was counselling. This allowed her to reflect further on the effects on her personally of listening professionally to the stories of communal trauma. This fits with an understanding of secondary traumatic stress from the foundational work of Charles Figley in which he describes secondary traumatic stress as, "the natural consequent behaviours and emotions resulting from knowing about a traumatizing event experienced by a significant other – the stress resulting from helping or wanting to help a traumatized or suffering person" (Figley 2002, p. 1435).

Therapists can be traumatised themselves while witnessing their clients' and families' re-telling of traumatic events during therapy. It could be expected that counsellors and therapists involved in the Black Saturday 2009 Victorian bushfires have the potential to develop secondary traumatic stress from their professional support to communities. For Anna, secondary traumatic stress was even more relevant as she was not only witnessing her clients' retelling of their trauma, but she herself had experienced the bushfires personally. While she didn't lose her home at this time, she subsequently lost her property in later fires in the Gippsland region, while continuing in a bushfire counselling role.

Anna's story of recognising her own experiences of secondary traumatic stress is of significance for other counsellors, therapists and government agencies involved in providing therapeutic support to rural communities following Australian climatic adversities. The wellbeing and professional support of counsellors and therapists themselves needs to be considered as they take up important roles of supporting affected rural communities. Issues of secondary traumatic stress are significant and need to be considered within local responses. The work of Figley and colleagues (Figley & Barnes, 2005, Figley & Kiser, 2013) on helping professionals working with traumatised families, provides a useful framework to structure response teams and their own therapeutic support to address secondary trauma. This is particularly important for small rural communities where health professionals who provide counselling and support, are themselves local. They remain living and working with

bushfire affected clients, while experiencing these same traumas. Stress and trauma related to these events is cumulative. It is worth noting that given the threat of ongoing climatic changes in Australia (Australian Bureau of Meteorology, 2007), these professionals require open-ended support to sustain themselves within these roles. This approach acknowledges and is consistent with understandings of rurality as contextual, relational and complex.

9.6 Jacqueline: “You’re the same person”

Jacqueline has a substantial history of personal and professional connections within the rural region where she lives and works. She has taught and practiced family therapy within both rural and urban settings for twenty one years. She begins her narrative by telling of how she transitioned her teaching of family therapy from an urban to a rural setting, because of geographical distances and inequity involved for her rural students. I begin the conversation by inviting her to talk about what is important to her about her rural family therapy practices:

> Annette: *So I’m happy to talk about anything that you want to about rural family therapy* (I look at Jacqueline as I say this to invite her to begin her story).
>
> Jacqueline: *Well we could start with how it umm started* [for me], *because that to me is a significant part because I was born in* [name of small town], *rural Victoria*.
>
> Annette: *Where is* [name of town]?
>
> Jacqueline: *Near* [name of another larger town close by that I recognise] (Jacqueline laughs when I recognise the larger town, but not her smaller local one).
>
> Annette: *You can tell I’m a Kiwi* [Slang for being born in New Zealand person], *I’ve got to ask!*

I say this with humour, as we have talked about where we and our families have come from in other conversations. This was an important part of identifying and

contextualising ourselves as therapists and people with each other when we first met.

> Jacqueline: *And I suppose just being around and so having a couple of rural students from* [name of rural town] *came to* [nearest city name] *and trekked to* [suburb within this city location] *every week. And the injustice of that sort of struck me at the time. About the you know, that's quite a bit of commitment. And of course because* family therapy, *the material of family therapy is so contagious they were taking that material back* [to their small rural town] *and they actually got into it, family therapy from someone who did the* [name of city family therapy training centre] *course.*
>
> Annette: Mmm.
>
> Jacqueline: *So she* [previous student of Jacqueline's] *took the information back, that triggered their interest and so two of them trekked down and then from there was more and more interest expressed, and so at some point it just occurred to me that's it's easier for me, one person to go up, than for …*
>
> Annette: *All them to trek down*. (I finish Jacqueline's sentence for her, as part of recognising and acknowledging her commitment to rural students. She nods at me while I say this).
>
> Jacqueline: *And I suppose it started* [Jacqueline teaching family therapy] *in* [name of town] *because I had some sort of sense of connection to* [this town] *even though I had not been there forever. But what I discovered straight away is the hunger for it. Rural people are really hungry for the information. They're, you know, they're just, how would you describe it?* (Jacqueline asks herself this question and pauses to think briefly) *And family therapy there was an automatic. I think* [there was a] *compatibility because some of them had done other sorts of training, like Gestalt or psychodrama. But their comments would often be that it didn't sit as well in the context they were working in,*
>
> Annette: *Yep.*

I nod in agreement to this statement and to encourage Jacqueline to continue her story.

Jacqueline: *As family therapy did. I think it's the, that secondary order cybernetic phenomena that you are a person going into the family and you carry your history in with you* …

Annette: *Mmm.*

Jacqueline: … *in a rural setting, you can, you can't pretend you're someone you're not because they will know who you are.*

Annette: *That's right* (Jacqueline and I look at each other and smile in recognition of this shared understanding of rurality).

Jacqueline: *Yeah so, so the thing with rural family therapy training is the contagiousness of it. The compatibility with the local community. And that sort of sense that, if you are able to come in with that lovely Minuchin* [famous structural family therapist] *idea really. That we're all families dealing with the same issues, in the same place. And so whether you meet them* [clients and families] *in the supermarket or you meet them in your office it doesn't matter, because you are the same person. And I think that's why family therapy really was so popular in the rural setting. So they [her students] did not have to try and pretend that they were something that they weren't professionally and personally when even one knew the truth.*

Annette: *Of who they were anyway*? (I look at Jacqueline and ask this as a question to confirm I understand what she has just said).

Jacqueline: *Yes* (She laughs).

Annette: *It's interesting you say that because other people* [in my research conversations] *have had conversations about the ethics of that. And the difficulties that other people have had about that. They have had clients who have travelled from other regions to come to them so they won't be known.*

Jacqueline: *Yes*.

Annette: *And what's happened is that the therapist has travelled somewhere and happened to be in that town or other region, you know. And the person* [one of their clients] *has seen them, as you do in small communities and that they haven't liked that. The client hasn't liked that at all.*

Jacqueline: *Yes. I see. I have never found that.*

Annette: *No I haven't either. But some people* [other therapists I have interviewed] *have talked about that. That there is that thing about again the personal professional thing.*

Jacqueline: *Yes. I'm not sure I, in the main even here in* [her current semi-rural location name] *because I'm working from here now. Like, I had someone who had lost my number* [see me] *in the hot bread shop the other day. And it was sort of, give me your number we need to come and see you* [and] *the hot bread shop was full.*

I laugh with Jacqueline in recognition of sharing the same experiences myself.

Jacqueline: *And she didn't care. So I was sort of thinking, because I've been around a long time* [as a therapist in this community] *and there were about three other people in the hot bread shop who knew who I was and what I would be doing. So the, "Are you sure you want to do this here,* [perhaps instead] *I'll ring you"? "No, no it's fine".* (Jacqueline repeats the question she asked her client and her client reply here). *Yeah so, that's that. Yeah there would be a lot of comments from* [her family therapy] *students. Even people who work for child protection in DHS* [Department of Human Services] *that is just the way it is. And the percentage of people who wouldn't want to be recognised, I would say they would probably be more in the elitist sort of category. For your average person, they don't care, they didn't care really. And I think that because of family therapy everyone* [her students] *had that whole transparency around everyone struggling with kids, or relationships, or the issues … Yeah they work in the communities they live in.*

Annette: That's right.

Jacqueline: Mmm.

Jacqueline's narrative suggests that there are differences between ethical dilemmas for rural practitioners compared to their urban colleagues. Rural differences are understood in terms of the smallness of many rural communities, where everyone often knows each other. Additionally, community members know each other in a dual or multiple relationships. For example, a family therapist might be known not only in their therapy role but also as a neighbour, friend, local committee member and general community member. Jacqueline describes her experiences of multiple relationships within an urban practice setting as being "*unusual*", while multiple relationships within her rural practice setting occurred frequently. Multiple or dual relationships within rural contexts complicate ethical considerations for family therapists in maintaining clients' confidentiality, as noted in my literature review (Bradley, Werth, Hastings, et al., 2012; Brownlee et al., 2010; Curtin & Hargrove, 2010; R. Green & Gregory, 2004; R. Green, 2003; R. Green, Gregory, & Mason, 2006; Halverson & Brownlee, 2010; Nelson, Pomerantz, Howard, & Bushy, 2007; Pugh & Cheers, 2010; Pugh, 2007; Scopelliti et al., 2004; Turbett, 2009; Werth et al., 2010; Zur, 2006).

For example, Bradley, Werth & Hastings (2012, p. 372) propose rural health practitioners:

> *not only serve a small community but are often part of the same community. Thus, the rural practitioner is faced with the complications associated with being a professional and person within a rural community, as opposed to being seen by clients only in a professional role, as is the case in larger areas.*

Being authentic as a person is important to Jacqueline's acceptance by her own community of her role as a rural family therapist. As she herself explains, "*you can't pretend you're someone you're not because they* [*her rural community*] *will know who you are"*. She calls upon eminent family therapist Salvador Minuchin's (1974) concept that we, as family therapists, face similar issues in dealing with our own families as our clients do to guide her practice. For Jacqueline this means being the same person in her relationships with clients, whether as a therapist or a community member. Her comments reflect an acceptance and theoretical conceptualisation of

the intimacy of the multiple personal and professional relationships practitioners face within small rural settings. Understandings of rurality as relational and complex are deepened in this concept of intricate layers of ethical issues for Jacqueline and other rural practitioners. For example, families attending therapy appointments with Jacqueline are frequently recognised by others from the same community. Families are, therefore, often known to be seeing her as a family therapist. Multiple relationships in small rural communities are somewhat inevitable for rural practitioners, requiring them to negotiate layers of ethical complexities in their personal and professional relationships. Jacqueline's theoretical understandings, based upon Minuchin's (1974) family therapy concept of being 'the same person' within multiple relationships with our clients is an important one for other rural practitioners to consider. Her more nuanced understandings of rurality allows practitioners to embrace rather than avoid the multiplicity and complexities of our relationships with rural clients. In addition, the relationships we have with clients is seen as dialogical and therapeutically relevant for clients, acknowledging our shared humanity as people facing similar issues in our lives. This understanding is consistent with multiple understandings of reality within social constructionist theory (Gergen & Gergen, 2008b), and the privileging of participants' perceptions as part of a PAR approach (Reason, 2006; Reason & Bradbury, 2008).

9.6.1 Jacqueline: "[a] process of subjectification"

Jacqueline and I have just finished discussing her story of being *"the same person"* as above, and we now move to talk about our stories of supervising family therapy students, and their dilemmas around multiple relationships. Within her role as a teacher of family therapy and a supervisor of clinical practice, Jacqueline came to know her students and their practice dilemmas well. Supervision of therapy practice during and following family therapy training seeks to develop and maintain professional practices of therapists (Australian Association of Family Therapy [AAFT], 2011c). Jacqueline offers one example from her family therapy supervision training with a student to illustrate the layers of ethical complexities involved in multiple relationships for them.

Jacqueline: *Which raises another issue about the country, is the whole confidentiality thing is a very interesting area. Because you know when everyone knows, you know* (Laughs with me, then pauses briefly).

Annette: *Yep. We've done supervision sessions and someone has presented* [a family by representing them on a whiteboard]. *And the moment they have got up to the fourth child, and have just started to explain the situation there's groans all around the room. And they go yes we know this family* (Smiling while I say this, in recognition of how common this is in supervising rural family therapy students).

Jacqueline: *Yes, which of course. Yeah and to be able to pull everyone together to be on the same page with that can be immensely helpful. But the issue she* [her student Jemma, a pseudonym] *often had was you know, the mother who made the notification on the neighbour's kids, wanting to know what the kinder teacher, whether she knew whether anything had happened, you know, that sort of, that's …*

Annette*: Yeah it get kind of complex doesn't it?*

Jacqueline: *It gets incredibly complex. Or getting information that something had happened from the neighbour, rather than actually from the family itself, so then what do you do with that information? You know all those sorts of things, it was very interesting. Again that happened occasionally in the city but it's very unusual, whereas they are daily occurrences in* [her rural setting], *or in the waiting room is another one that …*

Annette: *Yes, yes, it's actually yes* (Jacqueline and I laugh together recognising we share these experience). *I had that again the other week.* (More laughter together). *The young girl came in and said "Oh", as she came in. As you say, one young surly teenager saw the other surly teenager who was just leaving and said, "Hi, how are you?*" (More laughter together).

Jacqueline: *Yeah so confidentiality, it's just so different from all the things, the ways you would practice in the city. And of course it's often the city*

practitioners who are writing the textbooks and doing the, "This is the way it should be".

Jacqueline uses a different tone when saying these words. She then pauses for two seconds while looking thoughtful.

> Jacqueline: I*t's just not only, not helpful for the country but it undermines their practice and makes them feel like they are doing the wrong thing. And it actually introduces shame I think into their work, in a way that you wouldn't have if, that's why your thesis* [my research study] *is so important. Because that shame, you know, being an ex-catholic, it's almost like they come to confession sometimes in the supervisions. Because, "Look I did something the other day, that was really bad, I took so and so to a coffee shop and you know, a friend* (recognized them while out with you) *you know". And you know the question* [in supervision for Jemma was]*,"Was the client upset?" [Jemma then replied to her], "No, no, no she got up and she …"*
>
> Annette*: Said hello and it was all fine?* (I ask Jacqueline this question to confirm my understanding of what she has said. I calling upon our previous relationship and conversations about this topic to guess how she might end this sentence).

Jacqueline laughs at me in recognising I have guessed the end of the sentence correctly from our shared experiences as therapist.

> Jacqueline: *But she's* [Jemma's] *left with, she's breached protocol because she was taking this person to a coffee shop, and then they were recognised and blah blah blah and yeah.*
>
> Annette: *Yeah I think it's important too. You know I said, articles, I must send you the Zur article.*

I remind Jacqueline of a previous conversation we had in which I offered to share an interesting article by Zur (2006) I have found on confidentially and ethics while doing this study.

Annette: *Because he's the American guy who wrote a really great article that I read and I went aha* (said with strong emphasis to indicate I found this important)*. Like here's someone who is starting to write about something different* [on confidentiality in rural settings]. *And he talks about, um boundary crossings, he talks about confidentiality. In my words I interpret it as it's not so black and white. And I agree with you about the shame because I've had a lot of people, students and other professional colleagues who when they feel safe will say, "Oh I think I've done something dreadful. I've done da, da, da". And it's actually nothing that I think is ethically questionable at all. But because it's involved either seeming to be less professional and being more of a human person with them, or I mean they've had things like …*

Jacqueline: *Mmm well, they start with the premise that they are lesser than because they are in the rural …*

Annette: *Yes* (Said with strong emphasis in agreement with Jacqueline's statement). *Actually that's a really good point Jacqueline. A very good point. And so they look to um professional guidelines, professional standards, and there it's actually written …*

Jacqueline: *Yes*.

Annette: *You should not, so yeah, automatically* …

Jacqueline: *Go to the local coffee shop and say yes to, say hello to another client*.

Jacqueline finishes my sentence for me and then she and I burst into laughter together at the dramatic irony of her comment to us as therapists.

Annette: (Still laughing) *Yes, yes. So for them they just close down and when they are given the opportunity, as in one of our group discussions it's just, a huge discussion about it. Because it doesn't get discussed because people feel they are too afraid to talk about it. They have done something wrong and it's a totally different climate being rural, and they feel very relieved if we ever have a conversation. And I kind of say to students yes, like that's what*

happened in the waiting room with me with my, you know, young clients. And they were fine about it, matter of fact they have a bit of a networking group, they call it those people who see Annette.

Jacqueline and I again laugh together.

Jacqueline: (Still laughing) *and they refer each other.*

Annette: *Yes, so I think it is important so I will send you that article because I found it, and it's a lovely article, it isn't as black and white as urban based people think.*

Jacqueline: *And even in the urban based it can still get a bit blurry.*

Annette: *Yes but they don't agree about that I think, they try and make out it's very…*

Jacqueline: *But if you live and work, particularly over a long time you are bound to meet someone in a rural context sooner or later, unless you never go out and so …*

Annette: *Which wouldn't make you that a good of a family therapist, probably wouldn't get many referrals I suspect* (We laugh together).

Jacqueline: *So the whole premise that they are lesser than and that the people in the city have the truth. I think that whole process of subjectification I think is really quite powerful. And because they tend, which the other reason is why having it* [her family therapy training] *based rurally was so important, because they tend to go to the city, for their professional development. And so, so those things are always overlooked. Just you know, how you manage whatever it is and the whole yeah, what works in the city doesn't necessarily work in the rural sector. There's an assumption that it is, that everything's transferable, being based in the country. The other thing I think is that country people are more, this is a terrible generalisation, but they are more likely to think systemically, naturally because they are living in the context, and they are influenced by the context. So to be able to think of themselves as a little isolated pocket working in a sort of you know, sterilised environment is just*

something that doesn't generally sit well. Because they know that if, if there's a drought you know you've got to tend the landscape. You know there's just, there's just, it's almost like systemic thinking sits more naturally somehow rurally. Which is why family therapy did so well [In her community after students finished her training program]. *Whereas I think other people who have tried to take training rurally hasn't worked as well, like Gestalt* [therapy]. *I know of people who have tried to take Gestalt* [therapy] *rurally and I don't think that fits as well as say family therapy does.*

Annette: *OK, that interesting I hadn't thought about that. It's interesting what you say about the systemic thing because I think that too. It's almost like their system is not just their family, it's their whole family, their whole community.*

Jacqueline: *They are linked with the community*.

Annette: *And the land they live on and all the neighbouring, it's like they are a whole system, they are a whole system, and the whole region is a system.*

From her substantive history as a rural teacher and practitioner, Jacqueline draws upon her own understandings of Foucault's (1980) concepts of power and resistance, utilised in narrative therapy (White & Epston, 1990; White, 2007) to understand her student Jemma's (pseudonym) perceived "*breach of ethics*" as a *"process of subjectification"*. Jacqueline came to understand that a dominant urban based ethical guideline had informed Jemma's practice. This guideline suggested that client confidentiality was paramount. If a client was recognised while being with a therapist, a breach of protocol had occurred which was professionally negligent. There was no consideration of the context in which the client may have been recognised, such as the inevitability of such occurrences happening in small rural communities where it is likely clients will be known and recognised by others (Bradley et al., 2012; Pugh, 2007; Scopelliti et al., 2004; Werth et al., 2010; Zur, 2006).

This dominant urban-based guideline also applied to Jacqueline's family therapy group supervision. In line with these requirements (Australian Association of Family Therapy [AAFT], 2011) group members de-identified client and family details during

supervision. However, these guidelines did not acknowledge the frequency of multiple relationships in small rural communities for family therapists, creating uncertainty for practitioners in managing these. Jacqueline's story of Jemma's perception of *"shame"* is an excellent example of such uncertainty, where this student's own professional guidelines deemed that she had been unethical when her client was recognised in a coffee shop with her. A further example of the complexities of multiple relationships for rural practitioners, is that despite Jacqueline's supervision group strictly following family therapy ethical guidelines (AAFT, 2011c), the inevitability of multiple relationships meant that any of the families involved in any suspected abuse allegations spoken of by group members would quickly be identified by others in this group.

As my dinner guest, I ask Foucault to explain this process of subjectification to me so I can understand and utilise it within my analysis of this chapter. He suggests his focus in understanding power was not on how power exists within large organisations or governments, but rather in how power circulates within local contexts where people are subjected, or made into subjects by various means which he urges me to 'discover' within Jacqueline's story. He offers me the following statement to guide me in analysing his process of subjectification within Jacqueline's story of her student's *"shame*":

> rather than ask ourselves how the sovereign [supreme ruler government] appears to us in his lofty isolation, we should try to discover how it is that subjects are gradually, progressively, really and materially constituted through a multiplicity of organisms, forces, energies, materials, desires, thoughts etc. We should try to grasp subjection in its material instance as a constitution of subjects (Foucault, 1980, p. 97).

Utilising Foucault's explanation of the process of subjectification spoken of by Jacqueline, I further analyse her story of Jemma's experience of *"shame".* During her group supervision Jacqueline was able to highlight previously unspoken understandings of rural multiple relationships being subordinate to urban based ethical frameworks, which underpinned her student, Jemma's practices. That is, Jemma's sense of being "*wrong*" and "*breaching ethics*" was based upon an urban

based understanding of ethical multiple relationships that is not always achievable nor even desirable for rural practitioners. Jacqueline proposes that urban based practitioners are predominantly the ones writing ethical guidelines, and these guidelines are not always relevant to rural practitioners. She comments:

> *Of course it's often the city practitioners who are writing the textbooks and doing the 'This is the way it should be'. It's not only unhelpful for the country* [*practitioners*]*, but it undermines their practice and makes them feel they are doing the wrong thing and it introduces shame, I think, into their work*.

Jacqueline's story strengthens further a counter-narrative of rurality as deeply relational and profoundly complex. Within this counter-narrative, multiple relationships in rural settings are understood as an inevitable part of our therapeutic practices as family therapists. Additionally, this counter-narrative creates space for alternative understandings of Jacqueline's student, Jemma's actions. Her actions can be understood not as a breach of professional conduct, but rather as part of a wider sociopolitical context in which urban understandings of rurality dominate family therapy practices, including ethical complexities. Within this context, rural practitioners could potentially view themselves as lesser than their urban counterparts. As Jacqueline suggests rural people:

> *start with the premise that they are 'lesser than' because they are rural ... [and] that the people in the city have the truth ... That whole process of subjectification ... is really powerful.*

Discussion of multiple relationships by rural family therapists could be viewed as an "*unethica*l" practice from a dominant urban based ethical perspective, with significant professional consequences for therapists involved. This counter-narrative of rurality as relationally complex give voice to previously silenced alternative views of multiple relationships within rural contexts for Jacqueline's students and other rural practitioners.

Jacqueline's re-telling of Jemma's story is important in its illustration of the complexities of multiple relationships involved for family therapists working within small rural communities. While these issues are frequently cited within rural

literature, her story provides an intimate glimpse of the everyday practical issues faced by family therapy practitioners and students.

Another further deconstructed (Derrida, 1982) understanding of Jacqueline's story and her student, Jemma's sense of shame is that Jemma had raised this ethical dilemma in her supervision with Jacqueline because of her own isolation and lack of professional support working within a small rural community. These issues are well recognised in rural literature, presented in my literature review (Brownlee, Graham, Doucette, Hotson, & Halverson, 2009; Bowles, 2012; Congor & Plager, 2012 ; Curtin & Hargrove, 2010; Chenoweth, 2004; Crago & Crago, 2002; Hart, 1986; Martin, 2007, 2008; McGrail & Humphreys, 2009a; Pugh, 2007; Saunders, 1989; Weigel & Baker, 2002 ; Werth, Hastings, & Riding-Malon, 2010). Jemma sought to use family therapy training supervision to lessen her professional isolation and deal with an ethical dilemma in a constructive manner. Fortunately for her, Jacqueline as an adept family therapist, was able to provide this support using her own understandings of a Foucauldian concept of a process of subjectification (Foucault, 1980). However, other rural students might not be so fortunate in having access to such an experienced supervisor. These students could then be faced with the dominance of an urban based ethical guideline, overriding their rural practice experiences of multiple relationships. This in turn, could potentially create further uncertainty and shame for them, in their practices, such as that experienced by Jemma, which undermined her sense of competency and independence as an isolated rural practitioner.

9.7 Chapter summary

Eleni, Julia, Anna, myself and Jacqueline's stories in this chapter are representative of the importance of multiple relationships to all of my participants. We called upon qualities and theoretical concepts we have as family therapists in our narratives of understanding and negotiating multiple relationships. These qualities include an understanding of our own connectedness to our clients, and their families while living and working within small rural communities together. While all participants whose stories appear here agreed on the significance of their multiple relationships and community connectedness, each family therapist experienced this differently.

Eleni spoke of her strategy of "*breaking down*" her multiple relationships with students, and her ethical consideration of each of these relationships. Her strategy provides a useful conceptual guide for other rural family therapists in addressing relational complexities in a considered and ethical way. Mark's discussion of the complexities of multiple relationships for family therapists who have extensive histories as therapists in their region, underlines the inevitability of complex relationships in small communities. In Julia's story her community connection created a "*pressure*" and an increased "*expectation*" for her to engage and help everyone referred to her, which was unrealistic. She shared her own questioning of how these unrealistic expectations might impact on her ongoing personal and professional relationships within her community. These are useful questions for other isolated practitioners to reflect on understanding their own multiple relationships. For Anna, community connectedness facilitated her connection to clients. However it also contributed to her experiencing secondary traumatisation stress, while working as a bushfire counsellor following the 2009 Black Saturday Gippsland bushfires. Secondary traumatisation stress is an important consideration for rural family therapists and organisations involved in supporting communities during Australia's ongoing climatic adversities. Finally, Jacqueline's story and conceptualisation of one of her student's ethical dilemmas offers other family therapists important and alternative understandings of rurality as relational and complex. This counters dominant urban-based understandings of multiple relationships in rural regions as often unethical. Rural practitioners are able to access this counter-narrative, enabling their therapeutic practices with clients to be seen as inescapably relational and complex.

Overall Chapter Nine has offered intimate glimpses of participants' everyday experiences of working with multiple relationships within rural settings. Participants' stories illustrate how the complexities of professional and personal relationships between therapists, clients, clients families, and our communities, infuse, complicate, and enrich our therapeutic practices. How participants draw upon their own therapeutic practices to find a way forward within these complexities is summed up well in one participant's Julia's comment to me as I finished her group interview. She suggested, in speaking of what was important in therapy for her, that it's about "*the*

relationship" between a therapist, their client and their family. Consistent with Julia's focus on relationships, this chapter strengthens a counter-narrative of understanding rurality as relational and complex. Relational in terms of the extensive web of entwined multiple relationships we find ourselves within as rural family therapists in small communities. Complex in terms of the intricacy and slipperiness of ethical concerns involved in maintaining our clients' confidentiality within these multiple relationships, while acknowledging their therapeutic importance.

Chapter Ten

Rural family therapy training

Rural students have a *"thirst for knowledge"* (Mark).

10.1 Introduction

This final results chapter brings together all of my individual participants' experiences and learnings from teaching family therapy within rural contexts. All six of my individual participants, Roxy, Sigmund, Dorothy, Mark, Eleni and Jacqueline are involved in family therapy training of rural students. Their history of doing so is extensive, ranging from one to four decades of experience in teaching family therapy. As such, their mutual learnings contribute to our professional knowledge of successful rural teaching practices. In addition, their stories create a collective history of the development of rural family therapy training in Victoria, Australia. This history is an important part of our identities as Australian rural family therapists.

My approach to analysis in this chapter continues to be a layered one. Firstly, utilising narrative thematic analysis (Riessman, 2008) I gathered together sections of my individual participants' narratives related to their experiences of teaching rural family therapy. All of these sections were brief, except for the extensive narratives of Dorothy and Jacqueline. To retain the contextual meaning of Dorothy and Jacqueline's teaching experiences, within their overall narratives, their stories are told in full within Chapters Seven and Nine. In this results chapter I summarise themes from Dorothy and Jacqueline's previous full narratives to include their teaching experiences with other individuals' stories. These stories descriptively create a collective narrative of rural family therapy training.

The teaching experiences of my individual participants acknowledged traditional and alternative understandings of rurality. Their traditional understandings of rurality included percieving it as a deficiency of rural teaching experiences, such as the lack of access to training and ongoing supervsion for their students. Their alternative understandings of rurality included percieving it as a relationally important context, within which their students connected and networked together My analysis

accomodates all of these perpectives in two sections in this chapter, titled traditional and alternative understandings of rural family therapy.

Within my second layer of analysis I called upon my dinner party conversations with Jacques Derrida (1982) and Michel Foucault (1980) to deconstruct issues of power, and resistance within my participants' narratives. This analytical approach is purposeful to highlight alternative understandings of my particpants' teaching practices in rural settings. Jacqueline, as an experienced family therapist also utilises her own Foucauldian understanding of a "*process of subjectification",* whereby dominant urban based understandings of rurality marginalise and exclude rural families from services. My analysis of her, and other participants', stories further strengthens a counter-narrative of rurality as contextual and deeply relational.

10.2 Traditional understandings rural family therapy training

10.2.1 Sigmund's story

Sigmund had been living and teaching therapy in a metropolitan city prior to moving to a rural region in the early 1990s. His previous employment role involved providing training and development support to agencies in direct contact with disadvantaged families. He was also involved in giving advice for government policy development and research. As Sigmund met with agencies within this role "*people became aware of my background as a family therapist*" and became interested in therapy training. From this initial interest, Sigmund developed and delivered one day seminars in family therapy. This occurred "*twenty years ago*" when "*there weren't even very many one day workshops*" as happens currently. According to Sigmund, at the time such workshops "*just didn't happen and certainly not in the rural areas*".

From these workshops Sigmund noticed a significant interest by agencies in further professional development for their workers already involved with families:

> *It became clear that there was a very significant interest on the part of agencies to develop their skills and knowledge because they were already working with families.*

Many workers had skills which Sigmund describes as "*grassroots knowledge and expertise*". However there were few family therapists in his rural region at the time. Sigmund depicted this as being a time of family therapists being "*pretty thin on the ground in terms of knowledge and expertise".* As it became known that he had previously taught family therapy in a metropolitan city, Sigmund was then asked "*Would you teach it up here?*" He explained that the idea of providing training in his own rural region just:

> *…emerged, it came out of just my presence, talking about it and a need to formalise a process ... This is my language* [*of therapy*]*, to draw that connection between theory and practice, so that is how it emerged up here.*

Sigmund then went on to teach for "*about twenty years, like 1991, 1992 ... I don't have the number of people* [*I trained*] *but I would say one hundred to one hundred and fifty, around that number*". It gives Sigmund "*a bit of pleasure*" to have contributed to the development of therapy training in his region. Supported by other teaching therapists, Sigmund expanded the training program from being delivered just in Victoria to also being taught in Tasmania. He expressed the wish to explore adding online teaching to his delivery of local workshops in order to increase access to his training for rural and isolated students. During the writing of this thesis, Sigmund commenced his distance teaching of rural family therapy and has moved interstate himself. This online mode of teaching has provided for a more equitable access to training for rural students, while connecting them to each other and decreasing their professional and geographical isolation.

10.2.2 Gippsland group perspectives: A lack of professional support networks

The Gippsland focus group of James, Daisy Anna and myself identified that there are few opportunities for family therapists to meet, network and support each other professionally in their region once they had completed their therapy training. Daisy noted that "*there is no network ... we can be part of ... where you do reflective practice ... You never have that opportunity to brainstorm*". This concern with a lack of professional networks has been echoed by other participants, Eleni, Sigmund,

Roxy, and Jacqueline, alongside issues of professional isolation and the lack of access to professional development for rural therapy practitioners. These issues are frequently cited by rural practitioners and academics within rural health literature. As such, these issues remain important ones in considering how to provide future professional development to rural professionals, including rural family therapists.

10.2.3 Support for family therapy training and ongoing supervision

Another problem faced by rural family therapists is a lack of organisational support. Sigmund suggested there was for him a lack of organisational support and understanding, related to training staff in family therapy. He comments that there is an ongoing need for therapy supervision to enable practitioners to maintain their "*professionalism"*, noting that:

> *It's an issue that comes up frequently and not just in training but other work I do with a range of agencies, either in terms of consultation or supervision or debriefing etc. ... that agencies just don't seem to be willing to support their staff with time off or paying for training.*

Sigmund indicated concern at the lack of ongoing supervision of therapy practices for practitioners once they have completed their training, observing that "*very few people access ongoing supervision once they have completed* [*family therapy training*] *requirements*". He expressed a "*sadness*" that with regard to supervision there "*is an acknowledgement given that, yes, it's important ... but it just doesn't seem to happen*".

Sigmund reflected on the type of supervision that does happen in organisations he is aware of. He suggested that often such supervision is not clinically focused as is required within therapy practices. Instead, management style supervision, which involves checking staff productivity, occurs. He cited an example where in one agency:

> *It is not clinical supervision,* [*it*] *seems to be very little support in terms of reflecting on one's work. It's more like 'How's your caseload, are we meeting targets?'*

Family therapy clinical supervision is not understood as an ongoing requirement for professional development for practitioners. It is therefore not valued or supported by organisations, making access difficult for family therapists.

Sigmund also spoke of the lack of recognition of rural professionals' knowledge. Rural practitioners presume that they must travel to Melbourne to access expertise:

> *Like I said, there is some wisdom is Jesus' words ... Prophets don't have any honour in their own country ... There is something about the home-grown stuff not being recognised ... That mindset* [of] *'I've got to go to Melbourne* [for expertise].

Sigmund's comments expose an inherent assumption that expertise must come from outside of local rural contexts to be valued by those living within these communities. Rural as lesser than urban is a challenging concept to be considered by both rural and urban family therapists. Professional discussions could provide a space within which this concept could be unpacked, where competency based understandings of rural practitioners' expertise could be acknowledged in the development of future rural family therapy training programs.

The Tasmanian small group of Kitty, Julia, Audrey, Angel, Alana and I, also discussed the importance of ongoing professional support, specifically clinical supervision when working in isolation. Alana suggested:

> *You know the training is one thing but the actual sustainability of it when you work often in isolation ... as an individual family therapist ... it takes effort to sustain and maintain.*

Julia explained the difficulty of accessing supervision for her because of the considerable geographical distances involved. To access supervision she would have to travel to another state. She commented on clinical supervision:

> *That's a glaring gap ... It's not so easy to jump on a plane and fly to Victoria with a video in hand, but I'm ... not opposed to doing it if I can fit it in.*

It is not only access to supervision because of geographical isolation which is difficult for the Tasmanian group. Access to actual family therapy training is also a concern. As Alana observed: "*the first obstacle I think for us in Tassie* [*Tasmania*] *is not even having the training for family therapy*".

These comments from my Tasmanian participants draw attention to their geographical isolation from professional development opportunities, including family therapy training and ongoing supervision. In their previous narratives, Dorothy and Jacqueline have also commented on this geographical isolation for their family therapy students, resulting in them travelling, as teachers, to their students' own rural region to deliver family therapy training to them. Their purpose in doing so was to lessen the burden of travelling significant distances for their students. Likewise, Sigmund remains connected to my Tasmanian participants after he initially travelled to Tasmania to train them in family therapy. Many of my Tasmanian participants remain in contact with him, travelling interstate to see him professionally for family therapy supervision. The connection these participants and Sigmund have created together crosses the border of the Victorian and Tasmanian states, allowing them access to ongoing clinical supervision and networking opportunities together. Again, rurality is understood as relational in their narratives, underlining the significance of their professional connections together as rural family therapists.

10.2.4 Therapist self care

Mark has been involved in travelling to rural regions to teach family therapy for "*seventeen or eighteen years*". He was invited to teach in Sigmund's therapy program after they connected as professionals during their time together on the Victorian Association of Family Therapists (VAFT) committee. VAFT was then the professional organisation for therapists in Victoria, and subsequently changed to become the Australian Association of Family Therapists (AAFT), a national organisation. Mark recognised the need for therapist self-care, particularly in the rural context, because of the demands on rural practitioners discussed by his

students. These demands included "*the intensity of problems in the rural area*", such as high rates of suicide. He questioned how rural therapy practitioners "*can care for themselves at the same time as trying to do justice to the work that they've got to do, and how you balance that*".

Mark extended his notion of therapist self-care to include care of therapists' own families. He asked how therapists can "*care for their own families* [*with*] *the travel involved and just the intensity of the work*". Mark also identified from the literature that "*helpers like us have one of the highest rates of burnout of any profession*". He also questions how we, as helpers, can help others to become healthy if we are struggling to survive the demands of therapy practice: "*it's rather funny that we are trying to help people get healthy and ... we're half burning out ourselves*".

Mark's ideas of the need for a therapist's own self-care are significant for rural family therapists. His collective knowledge from teaching rural family therapy over two decades informs his focus on care of the self for both students and experienced therapists. How rural family therapists sustain themselves within their practices is a significant concern for Mark and for myself also as part of this study's focus. To address this concern, I now discuss participants' alternative understandings of rural family therapy training. These understandings focus on what is working well in family therapy training within rural contexts. In the sections which follow, I draw upon my participants' collective experiences of teaching rural family therapy. Their narratives call attention to the qualities of rural students spoken of by my participants, and the richness of students' connections to each other and their communities. Rurality is understood as relational within the teaching practices, and learning experiences of those involved in rural family therapy training.

10.3 Alternative understandings of rural family therapy training

10.3.1 "Thirst for knowledge"

The appetite of rural family therapy students for knowledge was commented on by my participants Roxy, Mark, Dorothy and Jacqueline in separate individual interviews when discussing rural family therapy teaching practices. Roxy described rural students as having a "*thirst for knowledge*" in her previous narrative which is shown

in their "*dedication*" to travelling large distances to attend training. Mark also used the word "*thirst*", in his expression "*thirsting for knowledge"*, to describe the eagerness of rural students to attend training. Like Roxy, Mark made reference to the distances of "*100 to 200 kilometres*" some students had to travel for training as a demonstration of their commitment to these courses. Dorothy's previous extensive individual narrative identified her rural students "*keenness*" to share their understandings of family therapy with others in their regions. In addition, that her rural students more quickly understood systemic practices and rural connectedness than her urban students.

Mark found teaching rural students an "*enjoyable*" experience, describing them as "*simple in a good sense or uncomplicated*" and "*more direct and easier to get through with, easier to join with*". He spoke of their "*naturalness*", saying they were "*easy to be with*". Indeed, he commented that he has "*knocked back*" some teaching offers because for him the teaching he offers needs to be valued by the students. He commented that the rural family therapy students he taught valued the need to learn: "*I like to teach where there was some value and it seemed like* [rural] *students were kind of willing to learn*".

Similar to Roxy and Mark, Jacqueline spoke of the appetite of rural students for knowledge, describing them as having a "*hunger for the information*" her training offered them. Jacqueline, in describing differences between qualities of urban and rural students, saw rural students as being "*much more courageous*". She explained this in reference to rural students being able to "*take on a new idea and have a play with it and develop it*". Jacqueline also spoke of rural students not placing themselves in a position as experts, which sometimes happens in an urban setting:

> *I think the rural students, there's not an arrogance that you sometimes get in (city name) ...* [of], *"This is an expert service, this is what we expect and this is the way it's going to be delivered".*

Jacqueline commented further on this metropolitan attitude, observing that "*you can get away with it in the city, that sort of arrogance, that because you're a professional, you're not human, rather than actually you're a human first*". She spoke also of the

reactions of her rural community to this metropolitan attitude of arrogance: "*you know potentially with some of the families in rural* [*areas*]*, you just wouldn't do that* ... *You'd be shot* [literally] *off the property*".

Geographically and professionally isolated family therapy students have shown both a willingness to learn and a dedication to the process of accessing available training. Participants' comments are important considerations for those seeking to develop relevant curriculum and engage with potential rural family therapy students.

10.3.2 Are rural family therapy students more systemic?

Mark experienced rural students as being more able to embrace and understand systemic family theory because in his view *"they were a systemic group to start with ... They came from all around*". He said that his students discussed their issues with work and the systemic challenges they faced, such as difficulties in travelling, in a way that included an understanding of wider perspectives, including those from sociopolitical and other contexts that systemic theory offers. Mark noticed his students discussing their "*systemic kind of issues and how they survived ... It was like looking at a big system much more consciously in the front of their minds*". Mark also experienced an immediate sense of contact with his rural students: "*I remember noticing quite clearly, it was an immediate sense of contact and you didn't have to work to get contact*".

Dorothy also commented on the qualities of her rural students. She suggested they have a "*charitable nature*", focusing on what they consider important in their practice. She described students who "*don't privilege money as much as metropolitan people, and so … they are prepared to work in agencies where they are getting less money*". She gave examples of students and agencies where this occurred, typically where the students and agencies have a social justice agenda. She reflected on rural students' abilities to connect and contribute to other people in general, as connectedness within her previous extensive narrative. Dorothy spoke also of family therapy training giving a "*common language*" to students and practitioners which they are able to use together when dealing with clients across different organisations and agencies.

Similarly to Dorothy, Jacqueline noted the helpful role family therapy training and the language involved had upon linking rural students, allowing them to network as professional colleagues. For her, the networking during training was:

> *… much more powerful in the rural groups ... Family therapy was a way to link them collegially that they had never experienced before and* [this was] *because family therapy has its own mindset and its own language.*

Jacqueline commented on the *"compatibility with the local community*" of her therapy training for students. Her training fitted well into the context of her students' work with rural families. Jacqueline gave an example of this link between rural students and therapists to their communities in her story of the funeral, which underlines an understanding of rurality as relationally complex.

10.3.3 Connections between rural students and their communities: The funeral story.

Jacqueline related the story of when she had a day booked for family therapy training that she had to cancel because a funeral of a local person was occurring at the same time. In a conversation with a colleague, she remembered them asking her "*What do you mean you've got to change the day for a funeral?"* Jacqueline's colleague did not understanding why she would cancel her training, allowing her students to attend a funeral instead. In her discussion with this colleague, Jacqueline explained that as "*most of the group* [*of her students*] *would be at the funeral*", it would be "*crazy to go*" to deliver the training because the majority of the students would not be there. Jacqueline's students privileged going to the funeral over therapy training because of their connection to the deceased and their community. Jacqueline recognised and understood her student's choice and was flexible in changing her training times to facilitate her student's attendance at this event. Her understanding of rurality was a deeply relational one of her students' connections to their community. In addition, she accepted the occurrences of everyday life in a rural context, where she and others may have little control over events. People, clients and students may have priorities other than therapy, which Jacqueline accepts. She explained:

> *It is acceptance that daily life happens ... There is this sort of elite, egotistical* [thinking] *that the therapy is so important that it has to have preference over everything else in life. That has permeated the rural sector. I think in the city, it is much easier to control everyday life. In the country it isn't because you're much more a victim of the environment.*

Jacqueline reflected "*you can't actually control the environment ... You never have that myth in the* rural *sector or rural family therapy*". Jacqueline's comments are an apt reminder to family therapists that we are often not able to control our environments, and that this is recognised more readily by rural therapists than urban therapists.

Jacqueline also commented on a disconnection she has witnessed "*from the land, which is happening more and more in (*name of city*),* [and] *is actually reflected in therapy practice*". Jacqueline and I had discussed together during her interview our shared experiences of times when rural families cancelled appointments, related to their attachment to the land. For example, rural families may cancel appointments due to their need to get their hay in because a storm is coming. Farming families cannot afford to lose their hay, as it is their income, and they therefore privilege tending to their land above attending therapy appointments.

Jacqueline suggested that one way of understanding cancelled appointments, based on a psychodynamic perspective of therapy, might be that clients are "*sabotaging*" their therapy, In contrast to this, Jacqueline understood rural clients as "*being pulled by the elements*". Further, she proposed that dominant urban based understandings of this rural 'pull' may be part of a *"process of subjectification by the city people on rural people".* She explained such urban based thinking at this time as*,* "…*we've got the right way of doing it in the city, so yeah, if you're going to preference hay, that, you know, you don't deserve my service*".

As an experienced family therapist, Jacqueline reflects Foucault's (1980) process of subjectification, to explain the dominance of urban based understandings of rurality, over rural based understandings of rurality within her hay story. She has explained her understanding of this Foucauldian process in her previous narrative, as part of

her experiences of multiple relationships in rural communities (Chapter Nine). Jacqueline's story reveals how the cancellation of therapy appointments by rural families was perceived by some other family therapists as their not being worthy of service, consistent with a dominant urban based understanding of rurality as lesser than urban. Such an understanding justified the marginalisation and exclusion of these families from family therapy services.

Jacqueline's story further describes her own Foucauldian analysis of a dominant urban based understanding of rurality. She offers an alternative understanding of why rural families cancel their therapy appointments. Jacqueline's new understanding is a rural based one which perceives her clients as being inextricably and deeply connected to their land, as both a lifestyle and income. This connection authorises them to cancel appointments to tend to their hay. This new understanding is consistent with a counter-narrative of rurality as contextual and relational. In addition, Jacqueline's acknowledgement of her clients' priorities creates opportunities for rural family therapists to engage with clients, thus enhancing our potential therapeutic work together.

While my participants' realisations can contribute much to family therapy training, there are several practicalities to consider as well. Based on their experiences, participants offer the following pragmatic suggestions about what works well in teaching family therapy in rural contexts.

10.4. Practicalities of rural family therapy training.

10.4.1 Roxy: "Don't start before 9am"

Roxy suggested there is a need for time for students to talk when they do finally meet for training. She highlighted how "*when they get together its 'natter, natter' ... It's like a family, they get together ... and they're busy talking and catching up, they hug one another*". Over time Roxy has observed that she and her colleagues never start the training at the designated time of 9am: "*When they* [students] *finally gather on the weekends* [for training], *we're supposed to start at nine. We never start at nine*". Students spend the time before the formal training connecting and networking, as their opportunities to do this with other therapists are limited. As Roxy says, "*the*

[training] *weekend is like a little oasis in the desert, of ... similar minded people ... where they ... talk about family therapy*".

Roxy understands that having this time for students to connect is a valuable part of their training program. Roxy's suggestions are useful ones for other practitioners to consider in structuring any future rural training. Students value relational connectedness to each other as part of informal networking opportunities. Building informal networking opportunities into formal training programs, acknowledges and affirms this relational connectedness as a crucial part of rurality for students. In addition, fostering the development of collegial support networks strengthens students connections to each other as a vital part of sustaining their professional practices as future rural family therapists.

10.4.2 Jacqueline: Mutual negotiations with students

Jacqueline outlined her method of teaching, which evolved over time using a "*lot of collegial type negotiation*" with rural students. She was influenced by narrative therapist Michael White (2007) and his method of teaching in consolidated blocks of time, to allow geographically distant students to attend the training. With this narrative therapy influence, Jacqueline "*put the training into three one week blocks over two years*". She found this a useful format for teaching as it gave her and her students *"lovely gaps between*" training times. She also suggested that a "*one off meeting here or there*" is useful for some training workshops, as it allows participants to engage when "*money is tight ... and they have a lot to do*".

For those students who have to travel a number of hours to get to the training venue, Jacqueline allows a later starting time. She also attends to their basic needs upon arrival, thus engaging them in the teaching process. Jacqueline explained how she does this by engaging in "*little practices*" of hospitality such as "*just giving people a cup of tea when they come in the door"* and pointing out to them *"there's the toilet*". By attending to these small but vital aspects of rural training, an immediate engagement with students is created, while also acknowledging the rural context within which they work and live. By consolidating training into short blocks of time, Jacqueline has tailored her teaching to fit the needs of her rural students. Many of

these students would not have been able to attend her training if they were required to travel for weekly attendance over the one to two years involved. Jacqueline's redesigned structuring of times into short blocks has allowed students otherwise disadvantaged by their location to access her training. This is a useful concept for all teachers of rural family therapy training to consider.

10.4.3 Eleni: Access to training programs

Individual participant Eleni also discussed rural family therapy training and access. She suggested that short courses are useful for rural practitioners, informed from her own experiences of commuting to a metropolitan city for family therapy training: "*You know, shorter courses ... I think there's a real place for that ...* [*A*] *one day a week for six months type of course*". Eleni advocated for both local and metropolitan options in family therapy training to be available for rural participants to access. She suggested that locally delivered training allows for a local "*connection*" between students who choose to remain within their region for professional development. However issues of multiple and complex relationships between those living in small rural communities remain, including for rural family therapy students. Given these complexities, Eleni suggested that some students prefer to train outside their rural communities. Metropolitan cities offer a space for these students to train away from intimate connections between their personal and professional lives. Eleni's ideas of short courses, and both local and metropolitan options in family therapy training are useful suggestions to consider for teachers of therapy contemplating future programs.

10.4.4 Dorothy: Group process

In addition to issues of travelling times, allowing for collegial networking and access to training for rural family therapy students, Dorothy adds the issue of group process. Dorothy and I share a history as psychiatric nurses of being trained in understanding the dynamics of how groups work together, and facilitating these subtleties to enhance learning for all those involved. We refer to these practices as group processes within our psychiatric nursing practices. Within her previous extensive narrative of coming to teach rural family therapy, she identifies the importance of facilitating group processes between students to enhance connections and

networking between them. In addition, Dorothy suggested that within these group processes, students can experientially learn about connectedness together. This then informs their therapy practices with clients.

Dorothy's promotion of group facilitation processes within family therapy training is a valuable concept for teachers of rural family therapists to consider. Group processes for students foster connections between rural practitioners. This contributes to the creation of a growing body of therapists who can professionally support and sustain each other in isolated rural contexts. These teaching practices are consistent with my goal of this study to find ways to nurture and support the sustainability of rural family therapist and their professional practices.

10.4.5 Jacqueline and Sigmund: Consideration of safety issues

Participants noted that a consideration of safety issues is useful when planning training involving rural practitioners who have to travel large distances. Jacqueline cited examples such as tiredness, length of time travelling and road conditions as issues to be considered by both students and teachers of therapy training. Sigmund similarly proposed that it is not safe for rural family therapists accessing training or professional development to be travelling excessive times to venues. He pointed out: "*No it's not safe for you to start driving at five o'clock in the morning and get home at nine o'clock at night*". For those practitioners involved in teaching family therapy, issues of safety for students and times involved travelling are important concerns to be addressed. It would also be useful to consider accommodation options for practitioners when planning family therapy training, so that rural contexts are acknowledged.

10.5 Chapter summary

This chapter has reviewed the extensive teaching experiences of my participants who are involved in rural family therapy training. I have presented these experiences as traditional and alternative understandings of rurality. My participants' interpretations of rurality provide significant and unique understandings of how to support family therapy training within rural contexts. In addition, practical suggestions from them offer guidance to others interested in teaching family therapy, as to how to

engage, negotiate and work with family therapy students in rural contexts. I summarise these suggestions below:

- The establishment of professional support networks for rural family therapists would provide opportunities for them to meet, network and support each other locally.
- Organisational support and understanding is required to facilitate students and staff attending rural family therapy training and ongoing family therapy supervision.
- Facilitating group processes during rural family therapy training to enhance not only students learning but also to facilitate their connections and networking together. This has the potential to promote the development of local options for professional support networks.
- Recognition by those involved in rural family therapy training of the complexities of students attending training and mutually negotiating ways to address these complexities with students. For example, the times and locations of training, safety issues for students travelling large geographical distances to access training, their driving times, road conditions and the inclusion of accommodation options for these students.
- Offering family therapy training as a short course in local rural contexts and metropolitan settings to maximise access for rural students.

My participants' traditional understandings of rurality underline the importance of equitable access to family therapy training and ongoing supervision for rural students. In addition, Mark raises the important issue of therapist self-care for rural practitioners working with, "*the intensity of problems in the rural area*", where, "*helpers like us have one of the highest rates of burnout of any profession*". Considerations o how to address these issues are crucial ones for those involved in rural family therapy, to ensure the professional development needs of their students are met.

My participants alternative understandings of rurality highlight a "*thirst for knowledge*" and community connectedness amongst rural family therapy students. Further, these understandings suggest rural family therapy students recognise systemic family

therapy practices more readily because of their connectedness and location within rural contexts. Systemic family therapy theory "*pulls together*" the work students do across regions and organisations. This enables them to conceptualise their work with families as systemic, not only in terms of their individual therapy, but also in appreciating systemic approaches to understanding whole rural communities and connections within these of families and family therapists to each other and local services.

Overall alternative understandings of rurality contained within my participants' stories, reinforce an indefatigable counter-narrative of rurality which has emerged within my results chapters. This counter-narrative now crystallises, providing a multilayered approach to understandings of rurality as contextual, diverse, deeply relational and complex**.** As such, this counter-narrative provides us, as rural family therapists, with new ways to conceptualise the rurality of our practice and teaching experiences. These new understandings of rurality deepen and enrich our professional practices, while highlighting how we sustain ourselves professionally within webs of community connectedness.

Chapter Eleven

My final discussion

"And now, the end is near, And so I face the final curtain".
(Frank Sinatra cited in Kelly, 2010, p.450).

11.1 Our collective dinner party discussions

All of my theory guests involved in my analysis have remained at our dinner party, listening to each other's conversations within individual results chapters. My French guests Michel Foucault, Jacques Derrida and Giles Deleuze suggest it is time for us all to take a short break. They want to go outside to enjoy the riot of orange, red and purple tones of a magnificent rural sunset beginning outside. I readily agree as I welcome the space to collect my thoughts before beginning the important work of discussing the significance of this study with my guests.

I challenge myself to deliberately sit silently on my own, mentally moving beyond the complexities of this study's development and implementation. I go back to what was important to me at the start of this project, six long years ago; rurality and the rural practice experiences of my participants. My deliberations evoke a sense of satisfaction and realisation for me. Satisfaction at what I have achieved in the near completion of this study, while recognising my desire to round out this study and the importance of its findings with my participants as part of my final dinner party conversations. I decide to invite my participants to now join me and my theoretical guests within our present event, to discuss the importance of our narratives of rurality co-constructed together. And further, how we might disseminate the significance of these narratives to wider audiences. Given the length of time since the commencement of this project with my participants, and the impracticalities of getting them all together at once, inviting them to join me and my current guests within a fictitious dinner party space provides me with a way of conversing with them symbolically.

My participants now join me at the empty dinner table. I explain that my theoretical guests will rejoin us shorty, after their break. My participants take some time to choose their seats, talking to each other while they do so. I use this time to offer them some light refreshments as most of the food has been eaten during this extended dinner party. Once they are comfortable I begin by thanking them for returning to talk with me and explain how I analysed the narratives of rurality we had created together previously. I share my excitement with them of the emergence of a new counter-narrative of rurality as relational; a community connectedness, which exists alongside the dominant stories of rurality that many of us as rural practitioners are familiar with. I explain dominant narratives to them as those in which we understand rurality from a primarily deficit view. That is, rurality as lesser than urban, a deficiency of resources, health status and professionals' practices. In contrast, I describe our new counter-narrative of rurality as relational, offering us more contextual, complex and diverse understandings of rurality which sustain and enhance our professional practices.

11.2 Utilising outsider witnessing practices

There is a flurry of animated discussions as my participants talk together excitedly about these findings. When I am able to draw them back from these conversations, I ask them if I can discuss an option for the dissemination of our counter-narrative of rurality to wider audiences with them. Seeing my audience nodding, I take this as an agreement to do so and continue speaking. I suggest to them that we use 'outsider witnessing practices' from narrative therapy (White, 2007), so that our conversations together, of the importance of our counter-narrative of rurality are supported while speaking to selected outside audiences.

In this therapeutic practice, the story told by the narrator is witnessed, heard and understood by others in the group as their supportive audience. Consistent with social constructionist theory (Gergen & Gergen, 2008b), stories told in such a way are then embedded within wider sociol contexts to ensure their continued existence. My choice in this approach is purposeful. Our counter-narrative of rurality as relational, challenges dominant urban-based narratives of rurality spoken of in my results chapters. Outsider witnessing practices counter this dominance while

affirming the existence and content of our new counter-narrative of rurality as relational. Further, these therapeutic practices uphold our counter-narrative as an alternative and legitimate way of understanding rurality in a different way.

My audience, as experienced family therapists, quickly grasp the concepts I have described and after some deliberation, we all agree to my proposal. My theoretical guests have returned in to our dinner party in time for this discussion and join in this part of our conversation. Michel Foucault (1980; 1982; 2000) and Jacques Derrida (1982) acknowledge their surprise at how their concepts of power and resistance, and deconstruction have been utilised within Narrative therapy, while acknowledging the usefulness of engaging in such approaches to identify power and disrupt its influences.

11.3 A presentation evening is created

Having agreed to utilising outsider witnessing practices to embed our counter-narrative, my guests and I then discuss who our broader outside audience might be and how we might structure such an event. We agree collectively that this audience is an important one to not only witness our collective counter-narratives of rurality, but also to support the emergence of further such stories. These stories are an important part of our practices which we use to sustain ourselves professionally, because of the relationality and community connectedness these stories speak of.

From this conversation my guests suggest that an evening presentation would be a useful event to which we could invite rural academics, health professionals, rural family therapists and counsellors, and any other interested rural practitioners to attend. By mutual consensus we also agree to remain together after this event to say farewell to each other in a final conversation to conclude our research relationships together. After further discussion we agree on the format of this event. My participants will each tell their own narratives of rural family therapy experiences and practices. Their stories will follow the same format of narratives presented in my results chapters, alongside any other stories my participants think important at the time. My Gippsland and Tasmanian participants will each present their narratives as two individual groups, mirroring our research conversations together. My individual

participants will each discuss their stories individually, consistent with our previous research conversations. My participants and I agree that our mutual purpose is to offer listeners more nuanced examples of rurality so that the complexities, diversities and relationality we have experienced within our rural family therapy practices can be witnessed, respected and accepted by our wider audience. Following my participants' narration of their stories, I will present a concise summary of the significance of these stories for other rural practitioners. In addition, I will conclude this event by discussing the important challenges and considerations I faced during this study and tell my own story of becoming a feminist researcher.

I will include traditional and alternative understandings of rurality in an attempt to counter the dominance of any perceptions of rurality over another. As Foucault (1980) reminds our group, our new counter-narratives of rurality cannot replace current dominant urban-based narratives of rurality. A mere replacement replicates the issues of power inherent in our everyday practices. Rather, Derrida (1982) comments, our counter-narratives of rurality are intended to sit alongside urban-based narratives of rurality in a deconstructed sense. These differing narratives are able to co-exist informing our professional understandings of the complexities of rural family therapy practices. Giles Deleuze re-quotes his previous comments in our dinner party group, which are useful in cultivating an acceptance of differences between our own group perceptions of rurality and those of our urban colleagues. He states, "The question is never this *or* that, but always this *and* that" *(*Deleuze cited in Wyatt, Gale, Gannon, & Davies, 2011, p.2*,* italics as in original).

I share my hope with my guests that in speaking our stories to a wider audience they will be continually co-constructed, deconstructed and reconstructed together again in a social constructionist, Derridean and narrative performance/dialogical sense (Gergen & Gergen, 2008b; Derrida, 1982; Riessman, 2008). This hope embraces a social justice approach, shared by all my participants which seeks to counter the marginalisation and oppression of our clients and their families, spoken of in our stories. This hope and the use of outsider witnessing practices in the re-telling of our collective counter-narratives of rurality, is consistent with feminist and PAR approaches (Herr & Anderson, 2005; Lykes & Mallona, 2008; Reason & Bradbury, 2008).

I advise my guests that I will have to discuss our presentation evening idea with my PhD supervisors, and that I will feedback to them the outcome of this conversation. The next day my PhD supervisors approve the planning of this evening event and we discuss ideas for a guest list. We decide together that a professional flyer will be distributed to relevant agencies and organisations, such as local health services, university departments, fellow researchers, local rural practitioners of all disciplines and anyone who works within a rural health setting that is interested in understanding rurality as part of their professional practices. I fed back this conversation to my guests to confirm this event.

A venue is booked and I worry that no one will come or alternatively, that too many people will come and I will feel overwhelmed. Fortunately a manageable number of people reply to our invitation. My guests and I arrive on the evening of our presentation to a room of assorted people from a wide variety of rural health and educational agencies and organisations. A little nervously I begin by introducing myself and the purpose of this study. I then introduce my participants and outline what we are going to share with our audience during this presentation. My participants then tell their stories of rural family therapy practice and teaching experiences, as we had previously planned: stories of rural practice, resistance and resiliency, transformation and change, intersectionality, multiple relationships and rural family therapy training.

Our audience is attentive during these stories and looks at me as I summarise the significance of the narratives of rurality we have just witnessed from their retelling by my participants. In continuing with the format of this presentation previously agreed upon with my participants, I now present my discussions of the significance of these stories.

11.4 New narratives

The experiences and practices of rural family therapy participants described during this presentation are diverse and complex. These experiences support a social constructionist view that there are multiple stories of rural family therapy practice,

and that no one story or experience is the only reality (Gergen and Gergen, 2008b). I hold this concept in mind while I discuss the potential significance of this study in offering alternative understandings of rurality to other health professionals. My focus in this discussion is on alternative perspectives of rurality. However, I do acknowledge traditional perspectives of rurality spoken of by my participants in their stories. In this discussion, I draw upon Riessman's (2008) suggestion that significant findings from narrative analysis can be generalised to other settings, as part of a case based approach to research. Further, that my narrative analysis offers "conceptual inferences" (p.13) to readers from my discussion of my participants' counter-narratives of rurality.

Only some of my participants' experiences and practices within this study support findings from rural health literature with a traditional perspective, which frequently understands rurality from a deficit orientation. That is, it focuses on the deficiencies of working rurally for practitioners as cited in my literature review. These deficiencies include feeling professionally isolated (Brownlee, Graham, Doucette, Hotson, & Halverson, 2009; Chenoweth, 2004; Congor & Plager, 2012 ; Curtin & Hargrove, 2010; McGrail & Humphreys, 2009a; Pugh, 2007; J. Smith, 2007c; Werth, Hastings, & Riding-Malon, 2010), having limited access to education and training (Bowles, 2012; Brownlee et al., 2009; Johnson, Brems, Warner, & Roberts, 2006; McGrail et al., 2011), and having limited access to supervision (Bowles, 2012; Curtin & Hargrove, 2010). Practitioners' stories, confirm the relevance of these issues for rural family therapists and other relevant health professionals working in rural contexts. Issues of concern such as these and others identified by participants within this study remain significant for participants and other health practitioners, requiring a continuation of current governmental rural health strategies to address these.

Alongside a deficit orientation, however, participants' experiences and practices also highlight alternative understandings of rurality. It is these understandings which were most significant to this study and which offer an important contribution to professional communities in understanding rurality in alternative ways. Participants' stories underline the importance of paying attention to local rural contexts so that these are understood and considered within professional family therapy practices. Rurality is understood by participants as more than just a landscape or physical

space. Rather, rurality is an intricate part of their lives, both personally and professionally. Participants are connected to each other, their clients and families, and communities in inevitably intimate ways because of the proximity of living together.

Rather than focusing predominantly upon deficit based understandings of rurality, participants' stories reflect alternative, more optimistic conceptualisations of their practices and lives within rural communities. These new narratives symbolise my participants' professional hopes and commitment to the families they work with and live alongside in small communities. I depict at this presentation these alternative and more optimistic understandings of rurality as a series of powerful collective counter-narratives of rurality, which emerged during my analysis. These counter-narratives perceive rurality as contextual, deeply relational, diverse and complex, and which resist dominant urban based understandings of rurality. I re-present these counter-narratives in my discussion and comment on their significance for other family therapists, health practitioners, relevant researchers and health policy professionals.

11.4.1 Rurality is contextual

Participants' experiences and practices presented at this evening event are contextual. That is, these experiences and practices are specific to the rural contexts within which they were created. This is in line with the social constructionist and feminist theories (Gergen & Gergen, 2008a, 2008b; Reid et al., 2006) which underpin this study.

Roxy and Sigmund's stories illustrate the importance of the rural context for the farming families they see. Roxy acknowledges these families reliance on their land for a living, adjusting her therapy appointments around their requirements to tend to their land and livestock. In addition Roxy recognises the traditional male dominance of land ownership in her rural region and their risk of suicide related to the failure of intergeneration farms. An understanding of the burden of failure frequently experienced by male farmers is an important part of suicide prevention. An understanding of these issues, early engagement, assessment and treatment for

depression for this population could contribute towards averting further tragedies from completed suicides.

Gippsland focus group participants' stories also mention this risk of suicide for male farmers. Their efforts to counter this risk include new creative ways to connect with farmers to offer counselling support, following the 2009 Black Saturday Gippsland bushfires. For example, helping farmers with physical tasks to "*unreel the wire*" to mend their fences. This strategy was a significant one for my Gippsland participants. It also has relevance for other health professionals wishing to engage with rural farming males. The health and wellbeing of males in rural regions is a particular concern within literature. This population is under considerable stress, a high risk of suicide, does not like to ask for help and is less likely to use mental health services (Alston & Kent, 2008; Alston, 2012b; Kutek, Turnbull, & Fairweather-Schmidt, 2011; Maidment, 2012; Misan, Lesjak, & Fragar, 2008).

The Gippsland participants' new practices of creatively connecting with rural males offer an important link between therapeutic support being offered and accepted by this population. By engaging in physical onsite visits and offering combined practical and psychological support, health professionals can work alongside this currently vulnerable population to address significant health concerns. Participants' observations and therapy experiences, in relation to working with rural families experiencing suicide, are poignant and relevant to other therapy and health professionals seeking to understand how to work therapeutically with these families during these tragic occurrences.

The significance of a rural context for his clients is also identified in Sigmund's story of his ability to acknowledge, accept and integrate rural famers and families *"suck it up*" attitude and openness to change in his therapy practices. Sigmund calls upon these rural families' attitudes to understand the issues they present with, and to provide useful metaphors for therapeutic work. For example, calling upon rural families' understandings of a "*lifecycle of the land*" and the accepted deaths of cows while calving may be a useful metaphor for families grieving over the loss of a significant person in their lives. Additionally, attitudes of *"things break and you fix it"* and *"you get on with it and try and to make the best of it"* could be used as

metaphors for clients in continuing to address family difficulties over an extended time. There is a cycle here of damage and repair, and recognising this means trying to "*fix it"* while continuing to work at making *"the best"* of the situation. Sigmund utilises important aspects of his farming clients' attitudes which arise from their connection to their rural contexts. A rural context impacts not only upon Sigmund's farming clients income and lifestyle, it guides how they understand and manage issues they bring to therapy.

The importance of an attachment to the land for rural families was presented by another participant, Jacqueline in her story. She sees life in a rural context as more closely linked to the land upon which families live and work, compared to the life of people in the city. This reliance on the land places many families not only at the mercy of the environment, but also natural disasters which occur upon it. These include the 2009 Black Saturday Gippsland bushfires (Australia Associated Press, 2009) which Jacqueline experienced and witnessed, both as a family therapist and rural person. Given the ongoing risk of Australian bushfires in rural regions it would seem imperative that rural health professionals are able to engage with male farmers to reduce their risk of suicide in the stressful wake of such events.

My participants' experiences are unique to each of their local contexts. Their stories underline the significant finding of this study that all rural is not the same. While I offer general findings from this study to other rural practitioners, I acknowledge that rurality is contextual. As such, I propose that to develop further professional knowledge of rural family therapists from contexts other than those in this study, more research is required. In addition, that future research considers the development of localised rural research studies involving local practitioners to ensure the relevancy of such projects to these family therapists' practices. Respectful, rural research would create opportunities for greater local contexts to be acknowledged and individual voices to be heard, understood and integrated into the development of appropriate solutions to localised rural health problems.

While this study's finding, that all rurality is not the same, fits with Dempsey's (1990) study of small Australian rural communities cited in my literature review, it differs in

an important way. My participants' stories within this project offer more optimistic understandings of living and working rurally than the somewhat pessimistic picture suggested by Dempsey (1990). Again this emphasises the contextual nature of rurality and the requirement to consider local contexts. One study cannot be generalised to represent all rural communities nationally.

11.4.2 Rurality is relational

My own and participants' stories suggest that we conceptualise rurality as relational. This is, we understand rurality as a relationship between ourselves as family therapists, our clients and their families, and our local communities. A conceptual thread of perceiving this relationality as a community connectedness is present in all of our stories. As such, this thread subtly underlines the significance in our narratives of our connections to each other as people in small rural communities. In addition, it highlights how we draw upon this community connectedness to sustain ourselves professionally while working in professional and geographical isolation as rural family therapists. Paralleling my PAR approach, this community connectedness not only professionally sustains my participants, it also enhances and enriches their practices. These enhanced practices are then returned to participants' communities within their therapeutic work with clients and families. This cycle is ongoing between my participants, their clients and families, and their communities as a mutually constructed, localised and valued partnership.

Stories from my Tasmanian participants, Gippsland participants, Dorothy, and Jacqueline illustrate how they drew upon their community connectedness to sustain themselves as professionals while grappling with local issues of concern for them. For example, my Tasmanian participants resisted a new referral system which was marginalising and excluding their clients from services. To counter this they called upon their already existing professional networks and connections to work "*in spite of*" this new system. In addition, Dorothy and Jacqueline's stories highlight the significance of this community connectedness in the training of rural family therapists. Both of their teaching practices acknowledge and work with the relationality between their students, themselves and their rural communities. As such, this community connectedness is utilised as part of their teaching

methodologies as well as being an important part of establishing a support network to professionally sustain their geographically isolated rural students.

A collective counter-narrative of rurality as relational emerged during my analysis. This counter-narrative offers new ways of conceptualising the important issue of the professional sustainability of rural health practitioners. Participants within this study sustained themselves by drawing upon their hopes, resilience and connections to each other and their communities. These are important qualities for relevant policy makers to consider in the recruitment and retention of rural health professionals, including students. Hope, resiliency and community connectedness provide sustenance for rural practitioners both personally and professionally. Inclusion of a consideration of these qualities, alongside more traditional approaches for the recruitment and retention of rural health professionals, provides a valuable strategy in understanding and sustaining these professionals within rural contexts.

Of significance, our collective understandings of rurality as relational are consistent with Indigenous people's ways of understanding reality. Chilisa (2012, p.116) explains that Indigenous people's ways of knowing are part of a relational epistemology where:

> Knowing is something that is socially constructed by people who have relationships and connections with each other, the living and the non-living, and the environment. Knowers are seen as beings with connections to each other, the spirits of the ancestors, and the world around them that inform what they know and how they came know it (p.116).

This is also consistent with social constructionism which acknowledges multiple realties and ways of knowing (Gergen and Gergen, 2008b). Knowledge is itself perceived as relational in an Indigenous people's collective way of knowing. This is in stark conflict with a westernised dominant epistemology in which knowledge can be attained and owned by an individual (Chilisa, 2012). My participants' and my own perceptions of rurality as relational fits within an Indigenous people's relational epistemology. As such, we are all connected in our shared humanity. My participants' pursuit of social justice for their marginalised clients becomes an activity

worthy for all health practitioners, as any improvement in our clients' lives benefits us all as humans.

11.4.3 Rurality is diverse

The concept of rurality is diverse and can be understood from multiple perspectives, including geographical, gendered, racial, cultural and social understandings of rurality as small communities (Chapter Two, Chapter Eight). My own and Gippsland participants' stories shared at this dinner party reflect the diversity of rurality and that of our Indigenous clients. Their narratives include those of resistance to predominant white, westernised ways of working with Indigenous peoples. My analysis revealed issues of power, privilege and oppression of white westernised practitioners, over Indigenous peoples, as part of an ongoing process of colonisation. Our narratives illuminate our struggles to understand difference between ourselves and our clients, in ways that do not marginalise them further. This is consistent with Young & Zubrzycki's (2011) call for non-Indigenous peoples to understand Indigenous peoples differently. Wading through multiple layers of oppression associated with issues of intersectionality with our marginalised clients, we came to understand our place of privilege as white, westernised middle class family therapists. However understanding power, privilege and oppression within an intersectionality framework is not a straight forward task. All of us experience some form of injustice while grappling with power issues (Roberts & Jesudason, 2013). For example, while we are privileged as white practitioners those of us who are women are also subjugated to dominant male conceptualisations of reality because of our gender.

The space of intersectionality is a slippery one. Negotiating our way through this perilous terrain has meant falling into the occasion pothole of privilege along the way. Dragging ourselves out from these potential pitfalls of despair, our Gippsland focus group has continued in our journey of social justice, because to do otherwise is unthinkable to us. Our rural family therapy practices have allowed us access to the lives of our clients, within which we have witnessed their oppression. Our challenge is to remain in our therapeutic space with these clients, while inching our way forward into new understandings of this oppression from our clients' own perspectives (L. Smith, 1999, 2012). In addition, to see, acknowledge and

conceptualise ourselves as privileged practitioners, while also remaining open to new ways of being with our clients that denies their ongoing colonisation in our practices with them (Pease, 2010). Further, that we promote collaboration and partnership with our clients and wider local and international communities, so that our struggles together achieve the social justice we are mutually striving for.

Our rural practices based in such contexts are also complex. Our understandings of rurality in such a space, are enriching and exhausting to our practices. As such, a counter-narrative of rurality as relational is steadfastly supported, while our location as rural practitioners reinforces the astonishing diversity of our clients and their needs that bring them to therapy. The way forward in our work with Indigenous families has been outlined by authors such as L. Smith (1999, 2012) and Pease (2010). Linda Tuhiwai Smith (1999, 2012) is informative in understanding how family therapists might address issues of cultural differences, power and privilege, missing from my participant James' interpretation of a generational poverty framework. L. Smith (1999, 2012) suggests that it is difficult to work from a privileged position as a white person, to understand alternative views of Indigenous peoples. She proposes that part of the process of undoing our privilege as white practioners, is to move beyond our own white frameworks of understanding. And further, to strive to view Indigenous peoples more fairly from within Indigenous peoples' own frameworks of understanding while doing so (L.Smith, 1999). In taking up these alternative ways of understanding, practitioners move away from continuing to impose dominant white culture upon Indigenous peoples and marginalising them further (Young & Zubrzycki, 2011). However, L.Smith (2012) does acknowledge that it is a "risky business' (p.198) for researchers to work with issues of oppression, power and privilege with Indigenous peoples. In our uncovering of these issues we face criticism from those who may wish these narratives to remain silent. For those practitioners committed to social justice her words of warning are a useful reminder to us of the power of dominant white, westernised narratives of white supremacy over Indigenous peoples. However, consistent with the traditions of rugged rural resilience and autonomy (A.Smith, 2003; Thorngren, 2003), I suggest that the most useful resources we have in understanding intersectionality issues in our own rural contexts, are those of our clients and ourselves, if we should chose to listen to them carefully enough.

While these understandings of rurality are complex, they allow for diversity and differences of race, culture, gender and class to be considered by rural practitioners for their own practices. These understandings also fit with earlier discussions in my literature review to consider alternative social aspects of rural, such as gendered and cultural perspectives, alongside more traditional views. The development of alternative social aspects of rurality allows for the inclusion of perspectives from previously marginalised groups, such as women, rural males at high risk of suicide, and Indigenous peoples. The development of diverse, social understandings of rurality provides health practitioners with alternative ways of understanding, engaging and working with these groups. Alternative social understandings of rurality are also important for those involved in developing strategies and policies to address the health care needs of prioritised, and often marginalised rural health populations. The development of local, contextual understandings of small rural communities enables the uniqueness of each small community to be included while planning future health care in collaboration with these populations.

In Chapter Eight, I proposed that rurality be considered for inclusion with other intersectionality issues of gender, class, culture and race. The experience of rurality has shaped participants' professional practices and their personal lives, complicating the therapeutic work they undertake with families within small communities. Participants' stories told this dinner party demonstrate the significance for them of their rural context, in addition to more traditionally accepted intersectionality issues concerning their professional practices with families and communities. The inclusion of rurality alongside these issues provides rural health practitioners with an acknowledgement of the challenges they face within rural contexts, while offering them a theoretical framework from which to address these.

11.4.4 Rurality is complex

Rurality is not only diverse, it is also complex across each setting, requiring localised understandings for issues of concern. For example, my participants' stories presented at this dinner party of experiencing ethical dilemmas of multiple relationships working and living within small communities. Traditional urban based approaches to understanding these ethical dilemmas have included labelling them

as unethical conduct. An alternative, rurally based understanding of these ethical concerns, defined as community connectedness, is offered in my participants' stories in Chapter Nine. This alternative understanding of multiple relationships within rural contexts as community connectedness, offers practitioners and policy professionals a potentially valuable new way of understanding these ethical issues from a rurally based perspective. Importantly, it provides opportunities for dialogue about ethical concerns between urban and rural health professionals within a framework of competence, rather than in terms of deficiencies of professional practices.

The rural contexts within which my participants live and work are also complex. Geographical understandings of rurality include Australian rural classification systems critiqued in my literature review. Within this critique McGrail and Humphrey's (2009a) Index of Rural Access allows for the inclusion of factors other than geography. However, it still focuses on larger scale understandings of rurality in its categorisation of populations' health care needs.

Participants' stories support the inclusion of local knowledge in understanding the complexities of each local community's health and social care needs. McGrail and Humphrey's (2009a) Index of Rural Access is a useful tool which could be used as a first step to understand population health care needs. The development of a second step, where rural health professionals undertake their own research and consultation with local communities could be combined with these first findings. This second step would enhance alternative understandings of rurality as relationally complex, while contextualising local populations' health and social care needs. The creation of a two-step process allows for the combination of bigger picture understandings of health care needs with the local, contextualised knowledges of rural communities. The potential outcome could be health care planning which is more finely tuned and relevant to the local rural community within which it was developed.

My participants and I co-constructed new understandings of rurality in our research conversations together. My analysis of these new understandings highlights the emergence of counter-narratives of rurality which understand rurality as contextual, relational, diverse and complex. These new counter-narratives challenge those already in existence within traditional rural health literature which understands

rurality from a deficit perspective. That is, rurality as lesser than urban. Rurality, in our collective stories, transforms within a 'line of flight', 'becoming' (Durie, 2009) a counter-narrative of rural resiliency and resistance to dominate urban-based deficiency narratives of rurality. Our new counter-narratives of rurality understand rural practice experiences as deeply relational, a community connectedness required by practitioners to live, work and sustain ourselves professionally within our communities.

This community connectedness extends also into new understandings of the importance of rural family therapy training for students. My participants' narratives identify their students' "*thirst for knowledge*" and appreciation of systemic approaches to understanding their clients and local communities holistically. A powerful counter-narrative of rural family therapy training as profoundly relational is offered in these stories. Students are connected to each other, their clients and their communities providing opportunities to understand how they have sustained themselves professionally in the face of rural adversities. Further research into these student webs of community connectedness would provide additional narratives of rural resilience to guide other practitioners seeking alternative, contextually specific understandings of rurality to guide their practice.

This is the end of my discussion of the significance of my participants' narratives. My participants have finished their contributions to this evening presentation and leave while I discuss the challenges and important considerations of this study, and how I addressed these with my audience.

11.5 Important challenges and considerations within this study

An important challenge within this study was that my participants were not able to be involved in an ongoing collaborative analysis of data together because of commitments to their therapeutic work. My original plan for analysis had participants and I analysing data from their written transcripts and DVD's together. Feedback from my participants, within a PAR cycle of planning, action and reflection (Herr & Anderson, 2005; Reason & Bradbury, 2008), was that they were only able to offer their initial comments and reflections on this data, rather than being involved in an

ongoing analysis with me. I respected and accepted this change in line with PAR principles. While participants were not as involved in my analysis of this study as I had hoped they would be, I did gain an important understanding of their perspectives as practitioners from their feedback. Participants were busy practitioners, many of whom worked in private practice. Time spent not seeing clients meant not earning an income. I therefore recognised and accepted that while this study had significance to me as a PhD student, it had less significance to my participants because their priorities were their clinical work and earning an income. Further challenges and considerations within this study are as follows.

11.5.1 Professional diversity and geographical distances

Rural family therapists come from a diverse range of professional backgrounds, including those from psychiatric nursing, psychology, social work and social welfare who were part of this study. While this professional diversity brings multiple perspectives to family therapy practices, it created a challenge for me in accessing participants for this study. Rural family therapists do not exist as a distinct group. They are dispersed across vast geographical distances nationally, making them difficult to locate. Often their family therapy practices are incorporated within the professional disciplines they use to define themselves. For example, participants described themselves as social workers or psychiatric nurses, rather than rural family therapists. It is important to note, however, that participants from this study did also classify themselves as family therapists working in a rural context, in addition to their other professional identities. This is important to consider when asking practitioners how they define themselves professionally.

Given the vast geographical distribution of rural family therapists nationally, I located participants for this study primarily through professional networks such as the former Victorian Association of Family Therapy (VAFT) and the new national body, the Australian Association of Family therapy (AAFT). While this study does offer perspectives from participants from the New South Wales border, Victorian and Tasmanian regions, other rural family therapists exist who were not included. This is a shortcoming of this study. Further research is required that extends this initial

study, by locating and including these additional practitioners so that their stories can also contribute to professional understandings of rural practices.

11.5.2 Timeframe for completion of this project

An important consideration for feminist researchers is to maintain our reflexivity and transparency in our interactions with participants (Etherington, 2007; Reid & Frisby, 2008; Reinharz, 1992). As such, I acknowledge that while I have strived to be both reflexive and transparent the length of time it has taken to complete this project may impact upon my full achievement of these goals. I was challenged by the six years it took me as a part time PhD student to complete this project. I commenced this study at Te Whare Wananga O Waikato, University of Waikato, New Zealand, in 2008, before transferring to Monash University in 2012. During this time, participants have moved on with their lives, including changing locations and indeed countries. In line with a feminist PAR strategy, I gave initial transcripts to participants. I also plan to give them a copy of my completed thesis, once it is assessed by examiners.

In addition, I acknowledge the extended timeframe for my completion of this project was also in tension with the spirit of a PAR project, whereby I had anticipated returning ongoing relevant analysis sections to interested participants, as a form of collaborative analysis. This was not able to be achieved due to my move from a New Zealand to an Australian university.

11.5.3 Complexity of theoretical frameworks and tensions

Another challenge I faced in this study was how to understand and analyse alternative understandings of rurality voiced by my participants. I required a layered and sophisticated analytical approach to unearth the subtleties of rurality suggested by them. My use of theoretical concepts from feminist and social constructionist theorists, alongside influences from French philosophers Foucault, Derrida and Deleuze were complex, requiring considerable explanation of their significance to this study. These theories provided me with guidance in developing and analysing this study, and allowed for diversity and difference to emerge within participants' narratives. However, comments from peers and previous readers of this study indicated that the intricacy of the theories used made for complex reading, with the

potential of distancing readers. To counter this perception participants' narratives are represented as they were spoken by participants, using everyday language to encourage continued engagement with my written account of this study. I also plan to utilise multiple strategies in the dissemination of this study's findings in recognition of the differing needs and interests of any future audiences. For example, offering both theoretical and practical findings via academic journals, relevant conferences and gatherings of family therapy professionals.

A further challenge of this study was the existence of theoretical tensions and practical realites of my clinical work during the life of this project for me as a feminist PhD student undertaking a PAR project. For example, PAR involves collaboration by a researcher with her participants requiring time to develop research relationships together. However, academic requirements for this project also constrained me within a designated timeframe to complete this project. My participants were required to return their feedback from transcriptions given to them within a timeframe created by me and my then supervisors to be reviewed together. Part of our review was to ensure this study was on track for completion within the university's timeframe. The timeframe privileged this project's completion over my participants' participation. To counter this privileging of my project's completion over participants' contributions, I sought to be transparent with participants regarding these theoretical tensions, in line with a feminist informed PAR project. I explained these tensions to my participants and my plans to complete this project in the allocated time, in line with university requirements. However, these tensions existed during the life of this project and as such I, as a feminist researcher acknowledge their existence, alongside my attempts to address them.

11.5.4 Challenges of narrative analysis

There are important challenges to be aware of in our use of narrative analysis. Firstly, interpreting narratives is complex during transcription and analysis; a researcher's own perspectives may be inserted into gaps within participants' stories while trying to make sense of them (Holloway & Freshwater, 2007). Secondly, narratives rely upon participants' memories of events. Memories are selective, vary over time and participants may choose different aspects of their story to tell at

different times. (Holloway & Freshwater, 2007). Thirdly, narratives have many recognised functions such as, storytelling, engaging and persuading listeners, however they also have a frequently forgotten role of misleading audiences (Riessman, 2008). Fourthly, narratives may be interpreted differently by each reader. While a researcher using narrative performative/dialogical analysis may come to understand her research narratives one way, others may interpret these same stories differently. Each person brings their own social and cultural positioning to interpreting stories (Riessman, 2008). Finally, narrative analysis requires stories to be analysed holistically. A researcher's choice of which story, or parts of participants' stories are analysed impacts significantly on how these stories are represented (Riessman, 2008). My challenge during analysis was which parts of stories to present to readers, which empathically reflected participants' perceptions of their rural practices. I also faced practical limitations of not being able to include all sections of my participants' stories within this thesis, due to word limit restrictions and an unwieldiness of content while attempting to do so.

While acknowledging these challenges, I preferred to continue to align myself within a social constructionist framework during my analysis. There was no one right 'truth' in my participants' narratives, rather multiple perspectives were possible. I understood participants' stories as their own versions of reality, with none more genuine than another. Gaps or omissions in stories, and how participants performed (Riessman, 2008) their narratives were an important aspect of analysis, but only within an overall holistic understanding of the meaning they made of their rural practices.

I continued to utilise feminist research practices of reflexivity (Reid & Frisby, 2008) and transparency (Etherington, 2007; Reinharz, 1992) to counter these challenges of narrative analysis. These purposeful practices increased my critical self-awareness during my analysis, centering me upon understanding participants' stories rather than my own. These practices lead me to ask, 'If many interpretations of participants' narratives is possible, with none more genuine than another, how can I to claim authorship of a trustworthy version offered to readers of this study?" To answer my own reflexive questioning, I adopted Riessman's (2008) strategy of a structural and thematic approach during my initial narrative analysis. Participants' narratives

include structural and thematic features within their stories (Riessman, 2008). For example, how these stories were structured or organised and themes within both individual and collective narratives.

In addition I had contextual information as an insider researcher during my analysis which other readers would not. An example of this was my understandings of participants' family therapy practices from working with them professionally. I was therefore able to interpret participants' narratives of rurality drawing upon structural and thematic features within their stories, alongside my extended contextual knowledge of participants' practices. I claim an authenticity and trustworthiness (Holloway & Freshwater, 2007) in my interpretation of participants' narratives, while acknowledging a social constructionist perspective (Gergen & Gergen, 2008b) of the multiplicity of participants' stories while doing so. While not all aspects of participants' narratives are included in this study, my purposeful selection of their stories was theoretically informed by social constructionism and feminisms, including researcher practices of reflexivity and transparency.

11.5.5 Critical 'moments' within this project

Concepts of transformation and change from the work of Deleuze (1988, 1995: Deleuze & Guattari, 1987; Davies & Gannon, 2009; St. Pierre, 2001) were important to my analysis and development of counter-narratives of rurality. To specifically locate these significant moments of change within this study I called upon Wadsworth's (2010) concept of 'critical moments' within research practices. One such 'critical moment' was the development of a theoretical ethical framework in a pre-research meeting within our Gippsland focus group. An important part of this study was the creation of this framework which allowed for diversities and differences between ourselves and those we spoke of to be acknowledged. Acknowledging these differences enabled intersectionality issues of race, culture, class, rurality and gender to be discussed. Our use of an ethical framework was significant in allowing marginalised understandings of rurality to emerge. As such, this framework provided the scaffolding from which we reached for new understandings of rurality. In stretching our perceptions beyond this platform, new

counter-narratives of rurality were co-constructed in our research conversations together

A further ‘critical moment’ (Wadsworth, 2010) of this study was the recognition by one participant, Daisy, that this PAR project gave us time together as a group to focus on our rural family practices that might not have otherwise occurred. When, as the researcher I asked what value this research project may have had for the focus group, Daisy offered the following:

> *I think the other thing, too, it’s the only, when you think about it, it’s the only time that we actually get together to sit, to actually have time and space to talk about what it’s like to do rural family therapy because we don’t have capacity to do it. There is no network.*

This ‘critical moment’ (Wadsworth, 2010) is a significant part of this study as it indicates that as a feminist researcher, I have been able to contribute back to participants’ own practices as rural family therapists in the creation of a reflective research space as practitioners within this project (Reinharz, 1992). Participants’ stories told within these spaces will hopefully also contribute to wider therapeutic communities’ understandings of the practices and experiences of rural family therapists, once disseminated, meeting my main aim for this study. Consistent with a feminist research approach (Hesse-Biber & Piatelli, 2007; Reinharz, 1992) I conclude this part of my discussion by telling my own story of undertaking this study and my own ‘critical moments’ while doing so.

11.6 My own story of becoming a feminist researcher

Personally, I found the experience of undertaking this feminist and social constructionist influenced, PAR study inspirational for me as a beginning feminist researcher. The theoretical fit of this study with my professional practices allowed me to develop an identity as a feminist practitioner researcher, which I have found a rewarding conclusion to this project personally and professionally.

My first personal ‘critical moment’ in undertaking this study was the realisation that I was a facilitator in the co-construction of research practices with my participants, as

part of a PAR approach. As such, I became aware that my own research questions were only initial ones, and that participants would have their own questions within this study. From this realisation I was able to move to a meta-perspective of this study, creating my own series of research(er) questions to guide me in this project. These questions became a catalyst for the development of further participant driven research questions, consistent with a PAR approach.

My secondly personal critical moment was a painful one. I experienced emotional distress during my analysis of my Gippsland participants' stories of intersectionality. To contextualise my analysis of this chapter I had sought out local histories of the Indigenous peoples, known as Gunnai Kurni people, from the Gippsland region. An Indigenous academic colleague loaned me one National text (Eckermann, et al., 2006) and two local Victorian texts (Gardner, 1983; Pepper & De Araugo, 1985) which documented Indigenous peoples' experiences during European colonisation.She commented to me that the words of these local Koori histories were not well known to many Gippsland people.

In reading this text I was overwhelmed with feelings of sadness and guilt related to the massacring of Koori people during colonisation. I called upon the work of feminist, bell hooks (1994) and her description of searching for theory to explain the emotional pain she had experienced. Her words resonated particularly for me in my own search for understanding cultural and racial differences in theory and practice:

> I came to theory because I was hurting-the pain within me was so intense I could not go on living. I came to theory desperate, wanting to comprehend-to grasp what was happening around and within me. Most importantly I wanted to make the hurt go away (p. 59).

In my search for theoretical understandings I came to understand my emotions as those Abrams & Gibson, (2007, p. 154) call 'white guilt' in not knowing these Indigenous histories previously. Even more distressing to me was a dawning understanding that it was my privileged position, as a white person, that had allowed me access to these Koori histories. I felt shame and dishonour that I was able to access to information and knowledge that my Indigenous academic colleague

advised me was denied to many local indigenous and non-Indigenous peoples. To know of the intimate history of violently induced deaths of local Indigenous peoples during European colonisation fuelled a growing sense of anger in me as a woman. I identified with a call to rage by Spivak who incited a student's emotions, rather than silence, in the privileged position he found himself as a white male during her teaching:

> Let's say, a young, white male student, politically- correct, who will say: 'I am only a *bourgeois* white male, I can't speak'...I say to them: 'Why not develop a certain degree of rage against the history that has written such an abject script for you that you are silenced'(Spivak as cited in Kinnvall, 2009, p. 320).

Influenced by this call to rage, I focussed my anger during my analysis upon including my participants' stories of working with Indigenous families, so that these families' narratives of oppression and marginalisation could be witnessed by my readers. This is consistent with my own and Gippsland participants endeavours to practice from a social justice perspective.

My third personal critical moment was in relation to our collective counter narrative of rurality as relational. Prior to this study I had suspected here was something significant in our rural practices as family therapists. However, I was surprised at the depth of relationality my analysis revealed. All of my participants described the significance of community connectedness in their stories. Dorothy's story captures this connectedness well in her depiction of "*gossamer threads of relationship"* which connect all of us to each other and our planet. While we may all have an attachment to this thread, I suggest that within small rural communities these threads are more intricately interwoven because of our geographical isolation and multiple relationships to each other. In addition, rural resiliency and a pragmatic need to make things work creates a powerful combination of personal attributes and communal characteristics as part of the relationality of rurality. Alternative understandings of rurality as relational, drawn from my analysis, are important to rural family therapists as this is how we sustain ourselves professionally.

My final personal critical moment was my recognition of the journey of transformation and change, influenced by the ideas of Deleuze (Deleuze 1988, 1995: Deleuze &

Guattari, 1987; Davies & Gannon, 2009; St. Pierre, 2001), that I had undertaken during this study. As part of this journey I came to appreciate feminist theories which provided me with concepts, such as, reflexivity to use as I negotiated the difficult path through the difficulties of achieving an ethical feminist research project. I survived the travel of getting the research 'done' and my journey through analysis offered me the possibilities of achieving a text that I had previously seen as being an ' impossible' (Lather,1991) task to complete. I was able to better understand myself as a woman and emerging researcher within the multitude of theoretical frameworks feminisms offered to me. In sum, pioneer FPAR researchers Frisby, Maguire and Reid (2009), succinctly capture the usefulness of feminist theories in my life and this project in their reference to feminist Dorothy Smith that, "theory is a tool to think with ..." (p.16).

11.7 Chapter summary

Within this chapter I have bought together threads of emerging counter-narratives of reality into a synergistic whole. Rurality is revealed as contextual, intensely relational, diverse and complex in our stories which counter dominant urban based narratives of rurality as lesser than rural. Our evening presentation has disseminated these counter-narratives to a wider audience so that they can be appreciated by a broader array of health professionals. And further, consistent with a narrative therapy approach (White, 2007), my hope is that these counter-narratives of rurality will evoke further such stories from other rural practitioners. As such, these stories can provide a source of inspiration for these professionals which they can draw upon in times of adversity to sustain themselves professionally. I have also reviewed important challenges and considerations relevant to this study, and shared my own learnings as a feminist research under taking this study.

Chapter Twelve

Conclusion: The story so far...

In considering how to conclude this study I was faced with another dilemma. Academic requirements insist that I produce a conclusion as a PhD student. However feminist poststructuralists, who have theoretically influenced this study, suggest theoretical work will never be finished. This study will always be a work in progress. To requote Davies et al. (2006, p. 100), "The work of feminist poststructuralism is, by definition, work that it can never complete". To address this dilemma I return to Kamler and Thomson's (2006) metaphor of a dinner party, used throughout my analysis discussions. This metaphor allows my participants and theoretical guests to have a final conversation and to farewell each other, as previously negotiated. This final conversation creates a space in which I can offer a partial conclusion to this study, while acknowledging the ongoing impact of participants' stories on me as a feminist researcher. I begin with these acknowledgments before offering readers a more traditional conclusion which highlights the main findings of this study.

In concluding our research journey my guests and I seat ourselves around the dinner table and they look to me for guidance as the host of this event. I ask if anyone has anything they would like to say in our final conversation and invite them to say their farewells to each other. In turn, each guest makes a comment and says goodbye to the group, some joining others in adding relevant details of humorous events, such as the Gippsland group laughing together over the "*BBQ story*". Their laughter dies, the table quietens and we realise our time together is over. My theoretical guests leave first, after acknowledging my participants and myself as the host. I then thank my participants as they rise and slowly leave, hugging and farewelling each other while planning the next time they will meet. In typical rural fashion, there is a lot of talk about when and how they will catch up, given the distances each has to travel and the busy schedules and family events they will have to navigate around. I am left with silence after their departure, a stark contrast to their previous noise presence. However, I am left also with a sense of friendship and belonging with and among my

participants who have departed. I feel gratitude towards my dinner party guests for the intimate glimpses of themselves and their practices they have shared with me. I consider their stories as a parting gift to me, one which I will treasure. Their gift contains qualities of joy and anguish from their experiences of rural family therapy, which I consider worthy of sharing with others in this written account.

This study has sought to contribute to the professional knowledge within the wider therapy community, and towards the growing body of literature on understanding rural issues in Australia. To this end, participants' stories analysed offer a valuable contribution in understanding rurality in new, vibrant ways. I reflect on what participants have offered me in terms of understanding not only their rural practices but the meaning of rurality itself through the stories they have told. It is these understandings which offer other, interested family therapists unique ways of conceptualising rurality.

Rurality within this study is understood as complex, diverse and specific to the localised contexts within which rural family therapists live and work. The focus of this research has been upon exploring participants' own chosen topics in relation to rurality. This focus has led to the identification of the importance of relationships, both between family therapists, their clients, families and communities, and defined more broadly as community connectedness, within rural contexts. This connectedness is valued by participants and utilised in their professional practices as family therapists. A powerful counter-narrative of rurality has emerged which offers other rural practitioners new more sustaining ways to conceptualise their rural practices. Rurality for rural family therapists in this study is, in sum, about connections and relationships between rural people.

Alongside understanding rurality as a relationship, participants' stories also emphasise the resiliency of rural practitioners, their clients, families and communities. Despite working with rural adversities, such as natural disasters and socioeconomic inequalities, and families from disadvantaged backgrounds, participants regained their hope of making a difference within rural communities. Their stories contain intimate descriptions of working with the multiple and diverse problems families bring to them as family therapists. Participants predominantly

focused on how they could facilitate change and transformation for the clients and families they worked with. Often participants extended their therapeutic work to consider systemic issues to achieve a wider understanding of socioeconomic and political contexts

The alternative understandings of rurality shared here provide other rural health practitioners, researchers and policy makers with opportunities to appreciate and conceptualise rurality differently. In so doing, health professionals and researchers have an expanded view to consider in producing further studies and scholarly works in the important area of rural health. I offer both traditional and alternative understandings of rurality back to participants and other readers of this thesis. I do this as part of a Derridean process of deconstruction which has unsettled traditional understandings of the rurality of family therapists' practices. From this unsettling, significant new counter-narratives of rurality have been unearthed and offered to wider audiences to embed them in wider sociopolitical contexts. Akin to rurality itself, the professional work that is undertaken by rural family therapists is diverse and complex. In a feminist poststructural textual move (Davies, 2005) I describe it as (Extra) ordinary, given the resiliency, sense of hope and commitment practitioners shared within their stories, while also working with rural limitations and adversities. For example, Dorothy's offering of "*gossamer threads of connection*" between her, her students, clients and wider communities provides other practitioners with alternative ways of understanding rurality as relational, countering traditional understandings of rurality as professionally isolated. James' BBQ story deftly exposes layers of complexity in understanding racial and cultural differences between himself, his clients and their communities. Rural practice is understood as a complex process of striving to understand these exposed complexities, while acknowledging wider socio-political and historical contexts and negotiating his way forward in his therapeutic practices with clients.

I maintain an ongoing hope that understandings of rurality from this study will provide participants and other interested family therapists, researchers and practitioners, with more socially just and contextually rich understandings of rurality, including rural practices and the relationships that exist between us and our small communities. I conclude this study by returning to my initial hope that this study and analysis of

participants' stories would offer new, alternative ways of understanding rurality which would be will be more sustaining of practice, and which will contribute to the professional knowledge of rural family therapy. By sustaining ourselves professionally we can remain available to families experiencing rural adversities, such as the ongoing drought and evolving lifecycles of families and their communities.

I believe I have realised my initial hope and now I embrace a new one. That is that stories of rural resilience and resistance continue to be told which offer hope and inspiration to rural practitioners seeking non-deficit based ways of understanding and working with marginalised rural clients and their families. To these rural practitioners, I conclude this study with the following quote, as a dedication to the complex theoretical and therapeutic work they undertake within small communities. It is not so much what we look at in our rural family therapy practices, but rather what we see and pay attention to. How we seek to understand that which is beyond our current understandings of rural family therapy practices. And further, how we conceptualise our perceptions in relation to socially just practices with marginalised clients and their families:

> It's not what you look at that matters, it's what you see (Thoreau, 1906, p.373).

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Appendices

Appendix A: Ethics approval, Te Whare Wananga O Waikato, University of Waikato, New Zealand.

Appendix B: Invitation to participate in a focus group, Albury-Wodonga region.

Appendix C: Invitation to participate in a focus group, Gippsland region

Appendix D: Invitation to participate in an individual interview.

Appendix E: Further written information on the research project for participants.

Appendix F: Notice of withdrawal from participation in research

Appendix G: Focus group, Albury-Wodonga region informed consent form

Appendix H: Focus group, Gippsland region informed consent form.

Appendix I: Individual informed consent form

Appendix J: Potential research questions for participants

Appendix K: Transfer of project from Te Whare Wananga O Waikato, University of Waikato, New Zealand, to Monash University, Australia.

Appendix L: Ethics approval, Monash University, Australia.

Note: All documentation sent to participants is presented here in its original format, following my ethical approval to do so.

Appendix A: Ethics approval letter, Te Whare Wananga O Waikato, University of Waikato, New Zealand.

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THE UNIVERSITY OF WAIKATO
Te Whare Wananga o Waikato

MEMORANDUM

To: Annette Woodhouse
cc Dr Elmarie Kotze and Dr Kathie Crocket

From: Dr Rosemary De Luca
Chairperson School of Education Research Ethics Committee

Date: 17 November 2008

Subject: Research Ethics Approval

The School of Education Research Ethics Committee considered your application for ethical approval for the research proposal:

Co-researching the (extra) ordinary experiences and practices of rural family therapists

I am pleased to advise you that your application has received ethical approval.

The Committee wishes you all the best with your research.

Dr Rosemary De Luca
Chairperson
For School of Education Research Ethics Committee

Appendix B: Invitation to participate in a focus group, Albury-Wodonga region.

An invitation to rural family therapists to participate in research that is interested in understanding who rural family therapists are and what working rurally might mean for our practice.

If you are a family therapist working in the Albury / Wodonga rural region of Australia, who is interested in exploring your experiences of what working rurally might mean to you and your practice then I would like to invite you to participate in this research.

I am conducting this research as part of my work towards a doctoral degree. My intention for this research is to collaborate with other family therapists in exploring our experiences and stories of rural family therapy practice. I am particularly interested in understanding how to sustain our rural practice in the face of ongoing adversity in rural regions. To achieve this I am inviting you to become a co-researcher with me in a focus group to discuss rural family therapy together, potentially using a family therapy reflecting team approach. I anticipate that the focus group will be made up of members from your local family therapy interest group. The focus group will be facilitated by me and we will meet in an initial pre-research meeting to collaboratively explore ways of working together, to develop the research process and questions. The time and location of the pre-research meeting will be one that is mutually agreeable to you and other focus group members and me as a researching practitioner. At this stage I am inviting you to a pre-research meeting at which the project will be further developed in consultation with the group. I am thinking that the overall project would be likely to involve you in about 3-4 hours of group meeting time, along with time reviewing a DVD of our meeting.

Unfortunately if you are a current client of the Gilead Downs Family Therapy Centre, Gippsland where I teach and practice I am not able to include you in this research, as this would be a difficult multiple relationship to manage.

My hope for this study is that it will allow new stories and identities of rural family therapists to emerge, that are more sustaining of therapy practice and allow rural family therapists and others to share what it means to experience family therapy in a rural region.

If you are interested in participating in this research, or taking part in a discussion to further clarify its possibilities before making a decision to participate, then please contact me for further information on the following means of contact : [redacted] anytime; Family therapy practice (Tuesdays) [redacted]. All contact numbers are confidential to me.

If you have any queries you would like to ask my Ph D supervisors at the Waikato University, their contact details are:

- Dr Elmarie Kotzé ([redacted] and
- Dr Kathie Crocket ([redacted])

Department of Human Development and Counselling
University of Waikato
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Hamilton
New Zealand
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Annette Woodhouse

Master of Family Therapy (Clinical) New South Wales Institute of Psychiatry, Sydney, New South Wales, Australia.
Victorian Association of family Therapists (VAFT) clinical member
Credentialed Mental health Nurse, Australian College of Mental Health Nurses.

Appendix C: Invitation to participate in a focus group, Gippsland region.

An invitation to rural family therapists to participate in research that is interested in understanding who rural family therapists are and what working rurally might mean for our practice.

If you are a family therapist working in the Gippsland rural region of Australia, who is interested in exploring your experiences of what working rurally might mean to you and your practice then I would like to invite you to participate in this research.

I am conducting this research as part of my work towards a doctoral degree. My intention for this research is to collaborate with other family therapists in exploring our experiences and stories of rural family therapy practice. I am particularly interested in understanding how to sustain our rural practice in the face of ongoing adversity in rural regions. To achieve this I am inviting you to become a co-researcher with me in a focus group to discuss rural family therapy together, potentially using a family therapy reflecting team approach. I anticipate that the focus group will be made up of members from your local family therapy interest group. The focus group will be facilitated by me and we will meet in an initial pre-research meeting to collaboratively explore ways of working together, to develop the research process and questions. The time and location of the pre-research meeting will be one that is mutually agreeable to you and other focus group members and me as a researching practitioner. At this stage I am inviting you to a pre-research meeting at which the project will be further developed in consultation with the group. I am thinking that the overall project would be likely to involve you in about 3-4 hours of group meeting time, along with time reviewing a DVD of our meeting.

Unfortunately if you are a current client of the Gilead Downs Family Therapy Centre, Gippsland where I teach and practice I am not able to include you in this research, as this would be a difficult multiple relationship to manage.

My hope for this study is that it will allow new stories and identities of rural family therapists to emerge, that are more sustaining of therapy practice and allow rural family therapists and others to share what it means to experience family therapy in a rural region.

If you are interested in participating in this research, or taking part in a discussion to further clarify its possibilities before making a decision to participate, then please contact me for further information on the following means of contact : [redacted] anytime; Family therapy practice (Tuesdays) [redacted] All contact numbers are confidential to me.

If you have any queries you would like to ask my Ph D supervisors at the Waikato University, their contact details are:

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Appendix D: Invitation to participate in an individual interview.

An invitation to rural family therapists to participate in research that is interested in understanding who rural family therapists are and what working rurally might mean for our practice.

Dear (name of individual identified family therapist)

I am aware that you have had extensive involvement in teaching rural family therapy from my discussion with family therapy colleagues, Maureen Crago (co-editor of Australian and New Zealand Journal of Family Therapy) and Victorian Association of Family Therapists(VAFT).I am currently planning to conduct research about rural family therapy experiences and practices and would like to invite you to participate in this research as I believe that your experiences of teaching therapy rurally would be valuable to this research .

I am conducting this research as part of my work towards a doctoral degree. My intention for this research is to collaborate with other family therapists in exploring our experiences and stories of rural family therapy practice. I am particularly interested in understanding how to sustain our rural practice in the face of ongoing adversity in rural regions. To achieve this I am inviting you to become a co-researcher with me in an individual interview to discuss rural family therapy together. The interview will be facilitated by me and we will meet in an initial pre-research meeting to collaboratively explore ways of working together, to develop the research process and questions. The time and location of the pre-research meeting will be one that is mutually agreeable to you and me as a researching practitioner. At this stage I am inviting you to a pre-research meeting at which the project will be further developed in consultation with you. I am thinking that the overall project would be likely to involve you in about 2-3 hours of meeting time, along with time reviewing a DVD of our meeting.

Unfortunately if you are a current client of the Gilead Downs Family Therapy Centre, Gippsland where I teach and practice I am not able to include you in this research, as this would be a difficult multiple relationship to manage.
My hope for this study is that it will allow new stories and identities of rural family therapists to emerge, that are more sustaining of therapy practice and allow rural family therapists and others to share what it means to experience family therapy in a rural region.

If you are interested in participating in this research, or taking part in a discussion to further clarify its possibilities before making a decision to participate, then please contact me for further information on the following means of contact : [redacted] anytime; Family therapy practice (Tuesdays) [redacted]; or via email at : [redacted] All contact numbers are confidential to me.

If you have any queries you would like to ask my Ph D supervisors at the Waikato University, their contact details are:

- Dr Elmarie Kotzé [redacted]) and
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Appendix E: Further written information on the research project for participants.

(Includes my own statement of personal and professional hopes and intentions for this project).

Research Title: “Co-Researching the (extra) ordinary experiences and practices of rural family therapists”

Researcher: Annette Woodhouse

a) Personal statement of hope and intention

b) Potential research process for participants

Thank you for expressing interest in this research project. This research is toward a Doctor of Philosophy degree from the University of Waikato in Hamilton, New Zealand (NZ). I will outline in the following (a) my personal intentions and hopes for this research (b) potential research process and safeguards for the confidentiality, privacy and anonymity for you as a co-researcher and (c) what is the next step if you wish to participate in this research.

I will start by introducing myself for those who do not already know me. My name is Annette Woodhouse. I am a clinical member of the Victorian Association of Family therapy Inc., (VAFT) and I practise family therapy privately part time at the Gilead Downs Family Therapy Centre, in Gippsland Victoria. I have studied family therapy at the Gilead Downs Family Therapy Centre Gippsland, Williams Road Family Therapy Centre Melbourne and the New South Wales Institute of Psychiatry. I am also a psychiatric nurse and lecture at the Monash University Department of Rural and Indigenous Health, Moe, Victoria, Australia. I have been married for 21 years and am a parent.

a) Personal statement of hope and intention

In this research project it is my intention to facilitate and nurture a spirit of professional collaboration with you as a participating co-researcher. I acknowledge that I have an ethical responsibility as a social constructionist and feminist researcher to be transparent with you as research participant (co-researcher) about my intentions and hopes for this research project. I have therefore included below part of my submission to the University of Waikato's Human Research Ethics Committee (NZ) so that you can access my thinking for this project.

My interest in rural family therapy as a research topic comes from a lifelong personal interest in how people relate to each other, and to my therapeutic work as both a psychiatric nurse and family therapist. I have worked therapeutically with mentally unwell people for the past thirty years as a psychiatric nurse in New Zealand and Australia and have been involved more specifically with children, adolescents and families, in rural and remote Victoria, Australia for the past nine years. This involvement lead to an interest in family therapy skills to meet the needs of the rural families I was working with.

Family therapy has grown in importance to me both professionally and personally. Family therapy and the different theoretical schools of thought contained within it have provided me with professional frameworks for practice with a significant therapeutic impact on my practice with clients. Family therapy has also given me a way of reflecting on and understanding my own life and family which has been helpful personally.

My interest in this topic is therefore driven by both a personal and professional curiosity about who are rural family therapists and what are their stories of practice? As a rural family therapist myself I am inevitably personally, as well as professionally, involved in the research process.

One social constructionist perspective of my research project is that it is not just about me as an individual, independent researcher but rather that the research process itself is a socio-political and socio-cultural event requiring me to engage in

"…facilitation of transformative, interactive, and dialogical practices…"(Etherington, 2007, p. 442).
My intention is to work alongside potential participants in an ongoing collaborative professional relationship moving towards the interactive dialogical practices Etherington (2007) calls for developing the research process, including the research questions, as the project proceeds.

In engaging in a collaborative, interactive relationship with participants I am aware that neither the participants or I can know *now* all of what we might be interested in knowing in the future as the research project progresses; what we come to know and learn together is co-constructed as we go and is therefore constantly changing (Etherington, 2007, p. 443).

To address potential ethical issues I intend to develop what qualitative researchers call reflexive relational ethics Etherington (2007) or relational ethics (Ellis, 2007, p. 3). These relational ethics "…require(s) researchers to act from our hearts and minds, acknowledge our interpersonal bonds to others, and take responsibility for actions and their consequences…" Ellis (2007).

Personal and profession hopes

My personal hope for this research project is that it will allow new stories from personal knowledges of rural family therapists to be brought together in ways that might sustain us, personally and professionally in the face of rural adversities, so that we remain available to the families and communities we work.

My professional hope for this research project is that the re-telling of our knowledge and experience of rural family practice together, and to others, will contribute to the wider family therapy community of practice, strengthening therapists' and clients' engagement with rural issues.

Potential research process

As you would have read in the invitation to participate in this research, this research is to collaborate and explore together experiences and stories of rural family therapy practice. To achieve this I invite you to become a co-researching participant with me in one of two focus groups to discuss rural family therapy. I hope to do this through facilitating a family therapy reflecting team approach. In a potential family therapy reflecting team approach the research meetings of the focus group are audio and video recorded. This is to allow for you as a participant to reflect later, upon your contributions. The purpose of this approach is to allow for multiple perspectives of participants' experiences and stories to be shared and includes an in depth reflection from participants and me as the researcher. This process is a tentative one as the choice of what we do in this project and how we do it together will be developed in consultation with you and the other focus group participants in our first pre-research meeting.

Safeguards, confidentiality, privacy and anonymity for participants

I understand that confidentiality, privacy and anonymity can be an issue in rural regions where we as family therapists are often known well by our communities and colleagues. I have in place confidentiality procedures so that your identifying details and identity will remain confidential including the use of chosen pseudonyms. I am aware that there are other issues such as unwitting participants and the potential for us to be exposed before our colleagues in conversations during the research process. My intention is that these ethical issues are discussed at our pre-research meeting and that we can collaboratively construct an ethical framework which will guide us in addressing these issues.

I will not reveal any identifiable information gained from this project to anyone through my doctoral thesis, or through being published, or presented at professional conferences. You will be requested to choose a pseudonym which will indicate your gender and I will take care to consult with you about any identifiable features (such as references to events in your rural area of practice) that arise during the research process so that you are represented in a way that is fitting to you and your professional practice .

Each co-researcher will be invited to review their own individual transcript and DVD taken from the whole focus group meeting and reflect on them and what they might contribute to the next research meeting from this review. I will respond to co-researchers requests for something to be changed or deleted. The videos, DVDs, audio tapes reflections and transcripts of the focus groups are confidential in that the only persons who will be able to view or listen to the tapes or see the full transcripts are myself and my two supervisors in New Zealand, Dr Elmarie Kotzé and Dr Kathie Crocket whose contact details are at the end of this information sheet. All transcripts, documents, DVD's images and tapes related to the research will be stored securely. Of course, material from the transcripts will be used in the study: in this sense it is your privacy that is protected.

Withdrawal from the research project

Withdrawal from being as a co- researcher (participant) in this the research can occur anytime up until three months after the final research group meeting or individual interview .To withdraw you can complete and post to me in the reply paid envelope the form attached at the end of this information sheet, "Notice of withdrawal from participation in the research". If you do need to withdraw for any reason whatsoever this is entirely appropriate and acceptable in this research.

The next step for interested participants (co-researchers).

If after reading this information sheet you choose to participate in this research, please read and sign the attached informed consent form and return it to me in the reply paid envelope. I will then write to participants to confirm your participation in the research and arrange a time for our pre- research meeting.

That is the beginning information on my research project. I welcome any questions about the information here at this time or at any time in the future.

Kind regards,
Annette Woodhouse.

Contact details for Annette's' supervisors are:

- Dr Elmarie Kotzé ([redacted]) and
- Dr Kathie Crocket [redacted]

Department of Human Development and Counselling
University of Waikato
Private Bag 3105
Hamilton
New Zealand
Phone: 0011 or 0018 647 838 4176

Appendix F: Notice of withdrawal from participation in research.

Research title: “Co-Researching the (extra) ordinary experiences and practices of rural family therapists”
Researcher: Annette Woodhouse.

I …… wish to withdraw from the research being conducted by Annette Woodhouse.

I know I do not need to give any reason for this decision to Annette.

I wish/do not wish to discuss my reasons for withdrawing. (Circle your preference).

I know that I can discuss my reasons for withdrawing directly or in writing with Annette or her supervisors.

I understand that my contribution thus far in this research will not be used in the thesis.

Please contact me/do not contact me to discuss this further. (Circle your preference).

Preferred means of contact:

I understand that Annette will be able to note in her thesis statistical information relating to my withdrawal. That is, she will be able to state the number of participants and what stage of the research they withdrew from, without giving any identifying information.

Signed: ……..Date: …….

Appendix G: Focus group, Albury-Wodonga region informed consent form.

Research Consent Form.
Research title: “Co-Researching the (extra) ordinary experiences and practices of rural family therapists”
Researcher: Annette Woodhouse.

I have read and understood the information for participants in this research which was given to me by Annette and have met with her to discuss this research.
I confirm that:
I understand that this project is guided by the University of Waikato’s Human Research Ethics Regulations. Annette has given me information about how she will take responsibility to safeguard my rights and ethical entitlements.

I agree to the video and audio taping of the focus group which will be facilitated by Annette. I understand that any recordings or written notes of the focus group will be kept securely and used for the purposes of this research project. I agree that the material as it is used in Annette’s doctoral thesis may be published, or presented at professional conferences by Annette.

I understand that not all of the material transcribed from the video, DVD and audio recordings of the focus group will be used in Annette’s thesis.

I understand that the material discussed in the focus group is private and cannot be discussed or used outside of that focus group except that material which has been agreed on to be discussed in subsequent research meetings together .I understand Annette’s intent is to develop ethical guidelines within the focus group to protect the privacy and anonymity of us as research participants and potential unwitting participants , such as clients and families . I understand that I can consult and discuss with Annette, her PhD supervisors and appropriate professional colleagues (such as supervisors) for guidance in dealing with any potential ethical issues related to privacy and anonymity.

I understand the intention of Annette to work in a collaborative professional relationship with me to shape the research process and questions together and that this will be done in a step by step process in consultation with me , Annette's PhD supervisors and the University of Waikato's Human Research Ethics Committee. I have been informed that our first pre-research meeting will be the setting to develop the next stage of the research project together.

I understand that the video, DVDs, audio tapes and transcripts along with this consent form will be accessible to Annette's supervisors to enable them to hold Annette accountable to professional standards and ethics and to provide safeguards to all participants. The supervisors will not reveal any identifying information about the participants to any other person.

Contact details for Annette's supervisors are:

- Dr Elmarie Kotzé ([redacted] and
- Dr Kathie Crocket ([redacted]

Department of Human Development and Counselling
University of Waikato
Private Bag 3105
Hamilton
New Zealand
[redacted]

I understand that I have the right to remove or alter information from my transcripts (if I choose to read them) but not change the content of the discussion as recorded in the transcript in ways that alters the meaning of the discussion of the other members. This also applies to any therapeutic documents Annette will send to us which will summarises the session, acknowledges co-researched stories and puts questions to shape our next discussion.
My preferred way of Annette sending me the written material letters and DVD's during the actual research process is recorded on the form attached to the end of this research consent form.

I understand that I will be participating in one of two focus groups which Annette will be facilitating; the time and location of these meetings is to be negotiated with the group. I understand that the content of these group discussions will also be negotiated with the group members in a pre-research meeting together.

I understand that I may withdraw from this research at any time up until three months after the final research group meeting. I understand that to withdraw from this research all I need to do is mail to Annette the “notice of withdrawal from participation in research” which is attached to the information sheet Annette has previously given to me. I understand that I do not need to provide an explanation for my withdrawal and none of my contributions will be used in her research report.

I understand that I can ask questions at any time and that these will be welcomed. This can be when we meet to conduct the research or via telephone or email as follows:

[redacted] anytime; Family therapy practice (Tuesdays) [redacted]; or via [redacted]. All contact numbers are confidential.

I understand that I have received the information I believe is necessary for me to give informed consent to participating in Annette Woodhouse’s research project and I agree to the terms outlined.

Signed: _____

Name: _____

Date: _____

Preferred way of written communication being sent to me and returned to Annette Woodhouse during the research process is: (Circle the mode you prefer).

Email.

Ordinary post.

Registered post.

Courier.

Preferred way of DVD material being sent to me and returned to Annette Woodhouse during the research process is: (Circle the mode you prefer).

Email.

Ordinary post.

Registered post.

Courier.

Your preferred contact details:

Name:……..

Address:……..

…….

Telephone:……...

Appendix H: Focus group Gippsland region informed consent form.

Research Consent Form.
Research title: “Co-Researching the (extra) ordinary experiences and practices of rural family therapists”
Researcher: Annette Woodhouse.

I have read and understood the information for participants in this research which was given to me by Annette and have met with her to discuss this research.
I confirm that:
I understand that this project is guided by the University of Waikato’s Human Research Ethics Regulations. Annette has given me information about how she will take responsibility to safeguard my rights and ethical entitlements.

I agree to the video and audio taping of the focus group which will be facilitated by Annette. I understand that any recordings or written notes of the focus group will be kept securely and used for the purposes of this research project. I agree that the material as it is used in Annette’s doctoral thesis may be published, or presented at professional conferences by Annette.

I understand that not all of the material transcribed from the video, DVD and audio recordings of the focus group will be used in Annette’s thesis.

I understand that the material discussed in the focus group is private and cannot be discussed or used outside of that focus group except that material which has been agreed on to be discussed in subsequent research meetings together .I understand Annette’s intent is to develop ethical guidelines within the focus group to protect the privacy and anonymity of us as research participants and potential unwitting participants , such as clients and families . I understand that I can consult and discuss with Annette, her PhD supervisors and appropriate professional colleagues (such as supervisors) for guidance in dealing with any potential ethical issues related to privacy and anonymity.

I understand the intention of Annette to work in a collaborative professional relationship with me to shape the research process and questions together and that this will be done in a step by step process in consultation with me , Annette's PhD supervisors and the University of Waikato's Human Research Ethics Committee. I have been informed that our first pre-research meeting will be the setting to develop the next stage of the research project together.

I understand that the video, DVDs, audio tapes and transcripts along with this consent form will be accessible to Annette's supervisors to enable them to hold Annette accountable to professional standards and ethics and to provide safeguards to all participants. The supervisors will not reveal any identifying information about the participants to any other person.

Contact details for Annette's supervisors are:

- Dr Elmarie Kotzé ([redacted] and
- Dr Kathie Crocket ([redacted]

Department of Human Development and Counselling
University of Waikato
Private Bag 3105
Hamilton
New Zealand
[redacted]

I understand that I have the right to remove or alter information from my transcripts (if I choose to read them) but not change the content of the discussion as recorded in the transcript in ways that alters the meaning of the discussion of the other members. This also applies to any therapeutic documents Annette will send to us which will summarises the session, acknowledges co-researched stories and puts questions to shape our next discussion.

My preferred way of Annette sending me the written material letters and DVD's during the actual research process is recorded on the form attached to the end of this research consent form.

I understand that I will be participating in one of two focus groups which Annette will be facilitating; the time and location of these meetings is to be negotiated with the group. I understand that the content of these group discussions will also be negotiated with the group members in a pre-research meeting together.

I understand that I may withdraw from this research at any time up until three months after the final research group meeting. I understand that to withdraw from this research all I need to do is mail to Annette the "notice of withdrawal from participation in research" which is attached to the information sheet Annette has previously given to me. I understand that I do not need to provide an explanation for my withdrawal and none of my contributions will be used in her research report.

I understand that I can ask questions at any time and that these will be welcomed. This can be when we meet to conduct the research or via telephone or email as follows:

[redacted] anytime; Family therapy practice (Tuesdays) [redacted]; or via [redacted] All contact numbers are confidential.

I understand that I have received the information I believe is necessary for me to give informed consent to participating in Annette Woodhouse's research project and I agree to the terms outlined.

Signed: _____

Name: _____

Date: _____

Preferred way of written communication being sent to me and returned to Annette Woodhouse during the research process is: (Circle the mode you prefer).

Email.

Ordinary post.

Registered post.

Courier.

Preferred way of DVD material being sent to me and returned to Annette Woodhouse during the research process is: (Circle the mode you prefer).

Email.

Ordinary post.

Registered post.

Courier.

Your preferred contact details:

Name:……..

Address:……..

Telephone:……...

Appendix I: Individual informed consent form.

Research informed consent form. (Individual).
Research Title: “Co-Researching the (extra) ordinary experiences and practices of rural family therapists”

Researcher: Annette Woodhouse.

I have read and understood the information for participants in this research which was given to me by Annette and have met with her to discuss this research.

I confirm that:

I understand that this project is guided by the University of Waikato’s Human Research Ethics Regulations. Annette has given me information about how she will take responsibility to safeguard my rights and ethical entitlements.

I agree to the video and audio taping of the co-research interviews which will be facilitated by Annette. I understand that any recordings or written notes of the co-research interviews will be kept securely and used for the purposes of this research project. I agree that the material as it is used in Annette’s doctoral thesis may be published, or presented at professional conferences by Annette.

I understand that not all of the material transcribed from the video, DVD and audio recordings of the co-research interviews will be used in Annette’s thesis.

I understand that the material discussed in the individual interview is private and cannot be discussed or used outside of that interview except that material which has been agreed on to be discussed in subsequent research meetings together .I understand Annette’s intent is to develop ethical guidelines with me to protect the privacy and anonymity of me as a research participant and potential unwitting participants , such as clients and families . I understand that I can consult and discuss with Annette, her PhD supervisors and appropriate professional colleagues

(such as supervisors) for guidance in dealing with any potential ethical issues related to privacy and anonymity.

I understand the intention of Annette to work in a collaborative professional relationship with me to shape the research process and questions together and that this will be done in a step by step process in consultation with me , Annette's PhD supervisors and the University of Waikato's Human Research Ethics Committee. I have been informed that our first pre-research meeting will be the setting to develop the next stage of the research project together.

I understand that the video, DVDs, audio tapes and transcripts along with this consent form will be accessible to Annette's supervisors to enable them to hold Annette accountable to professional standards and ethics and to provide safeguards to all participants. The supervisors will not reveal any identifying information about the participants to any other person.

Contact details for Annette's supervisors are:

- Dr Elmarie Kotzé ([redacted]) and
- Dr Kathie Crocket ([redacted]

Department of Human Development and Counselling
University of Waikato
Private Bag 3105
Hamilton
New Zealand
[redacted]

I understand that I have the right to remove or alter information from my transcripts (if I choose to read them) but not change the content of the discussion as recorded in the transcript in ways that alters the meaning of the discussion to the contributions of the other members. This also applies to any therapeutic documents Annette will

send to us which will summarises the session, acknowledging co-researched stories and putting questions to shape our next discussion.

My preferred way of Annette sending me the written material letters and DVD's during the actual research process is recorded on the form attached to the end of this research consent form.

I understand that I will be participating in an individual interview which Annette will be facilitating; the time and location of this meeting is to be negotiated with me and that. I understand that the content of these interviews will also be negotiated with me in a pre-research meeting together.

I understand that I may withdraw from this research at any time up until three months after the last interview .To withdraw from this research all I need to do is mail to her the "notice of withdrawal from participation in research" which is attached to the information sheet Annette has previously given to me. I understand that I do not need to provide an explanation for my withdrawal and none of my contributions will be used in her research report.

I understand that I can ask questions at any time and that these will be welcomed. This can be when we meet to conduct the research or via telephone or email as follows:

[redacted] anytime; Family therapy practice (Tuesdays) [redacted] or via email at: [redacted]u. All contact numbers are confidential.

I understand that I have received the information I believe is necessary for me to give informed consent to participating in Annette Woodhouse's research project and I agree to the terms outlined.

Signed: _____

Name: _____

Date: _____

Preferred way of written communication being sent to me and returned to Annette Woodhouse during the research process is: (Circle the mode you prefer).

Email.

Ordinary post.

Registered post.

Courier.

Preferred way of DVD material being sent to me and returned to Annette Woodhouse during the research process is: (Circle the mode you prefer).
Email.

Ordinary post.

Registered post.

Courier.

Your preferred contact details:

Name:……..

Address:……..

Telephone:……

Appendix J: Potential research questions for participants.

The following research questions are potential ones as they are subject to change following consultation with participants. Any changes from the consultations with participants to the questions presented here will be re-submitted to my PhD supervisors and the ethics committee for guidance and approval and this process is also discussed in section (c) of my ethics application.

Pre- research questions

I have created the following pre-research questions influenced by family therapist Tomm Andersen(Andersen, 1987, 1992). Andersen's purpose in his questioning of families at the beginning of a therapy session is set aside assumptions they may have about the therapy, review the history of why families have sought him out and discuss how they might talk together in a way most helpful for them(Andersen, 1992, pp. 61-62). I intend to use these pre-research questions to focus participants and me as a researcher, on how we might work together in a way that is meaningful for participants.

What would be the most helpful way for us to talk together about your rural family therapy experiences and practices?

When you knew we were going to meet today for this pre-research meeting what were you thinking might happen?

Did you have any particular ideas of what you did (and didn't) want to happen or talk about?

What is important for me to know about you as a potential co-researcher and therapy colleague?

Is there something else that I should be asking, that I do not know about that is important to you?

Is there something else that you would like to be able to say that you have not been able to yet?

Is there anything you would like to ask me about as a therapist, researcher, woman, colleague or person?

Potential Research questions

What would you say is particular about rural family therapy in Australia?

Have all your experiences of family therapy been rural ones? If so, what effects would you say this has had for you/your professional practice/your life? If not, what does the other experience make visible about family therapy in rural areas?

How has the experience of being a rural family therapist shaped who you are both personally and professionally?

In what ways does the geographical landscape shape
(a) your sense of self?
(b) the difficulties which rural families bring to family therapy?

How do you sustain yourself in family therapy practice while working in rural areas?

Post research question

This question is intended to encourage participants to reflect on any impacts there has been of the research project itself on them or their practice and what this might mean for them.

How has taking part in this research project contributed to your practice as a rural family therapist?

Appendix K: Transfer of project from Te Whare Wananga O Waikato, University of Waikato, New Zealand, to Monash University, Australia.

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

PLEASE NOTE: To ensure speedy turnaround time, this correspondence is now being sent by email only. MUHREC will endeavour to copy all investigators on correspondence relating to this project, but it is the responsibility of the first-named investigator to ensure that their co-investigators are aware of the content of the correspondence.

19 November 2012

Dr Anske Robinson
Rural and Indigenous Health
Medicine, Nursing and Health Sciences

Dear Researchers

Project Number: **CF12/3055 - 2012001557**
Project Title: **Co-researching the (extra) ordinary experiences and practices of rural family therapists**
Chief Investigator: **Dr Anske Robinson**

The above application has been reviewed by the Monash University Human Research Ethics Committee (MUHREC) which has determined that the proposal satisfies the terms of the National Statement on Ethical Conduct in Human Research 2007.

Therefore, MUHREC has granted a transfer from Waikato University, Hamilton, NewZealand of the research project, as described in your proposal, commencing on 28 June 2012 until 25 July 2016.

Please remember to convert all documents associated with this project (eg: Explanatory Statements, Consent Forms, Questionnaires and MUHREC contact details for Complaints – refer to http://www.monash.edu.au/researchoffice/human/additional-docs.html for templates) to Monash University Letterhead / Logo.

Thank you for your assistance.

[redacted]

Professor Ben Canny
Chair, MUHREC

cc: Ms Annette Marie Woodhouse

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
[redacted]www.monash.edu/research/ethics/human/index/html
ABN 12 377 614 012 CRICOS Provider #00008C

Appendix L: Ethics approval, Monash University.

MONASH University

Monash University Human Research Ethics Committee (MUHREC)
Research Office

Human Ethics Certificate of Approval

Date:	**11 October 2012**
Project Number:	**CF12/3055 – 2012001557**
Project Title:	**Co-researching the (extra) ordinary experiences and practices of rural family therapists**
Chief Investigator:	**Dr Anske Robinson**
Approved:	**From: 11 October 2012 To: 11 October 2017**

Terms of approval

1. The Chief investigator is responsible for ensuring that permission letters are obtained, if relevant, and a copy forwarded to MUHREC before any data collection can occur at the specified organisation. **Failure to provide permission letters to MUHREC before data collection commences is in breach of the National Statement on Ethical Conduct in Human Research and the Australian Code for the Responsible Conduct of Research.**
2. Approval is only valid whilst you hold a position at Monash University.
3. It is the responsibility of the Chief Investigator to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as approved by MUHREC.
4. You should notify MUHREC immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
5. The Explanatory Statement must be on Monash University letterhead and the Monash University complaints clause must contain your project number.
6. **Amendments to the approved project (including changes in personnel):** Requires the submission of a Request for Amendment form to MUHREC and must not begin without written approval from MUHREC. Substantial variations may require a new application.
7. **Future correspondence:** Please quote the project number and project title above in any further correspondence.
8. **Annual reports:** Continued approval of this project is dependent on the submission of an Annual Report. This is determined by the date of your letter of approval.
9. **Final report:** A Final Report should be provided at the conclusion of the project. MUHREC should be notified if the project is discontinued before the expected date of completion.
10. **Monitoring:** Projects may be subject to an audit or any other form of monitoring by MUHREC at any time.
11. **Retention and storage of data:** The Chief Investigator is responsible for the storage and retention of original data pertaining to a project for a minimum period of five years.

[redacted]

Professor Ben Canny
Chair, MUHREC

cc: Ms Annette Woodhouse

Postal – Monash University, Vic 3800, Australia
Building 3E, Room 111, Clayton Campus, Wellington Road, Clayton
[redacted] www.monash.edu/research/ethics/human/index/html
ABN 12 377 614 012 CRICOS Provider #00008C