



The therapist's experiencing in family therapy practice

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The question posed in this article is how the therapist should deal with strong emotions she might experience in the session. This question is especially important if it concerns emotions that –at least on the surface– cannot be considered to contribute to a therapeutic alliance. We offer some reflections as preliminary steps towards answering this question and propose that therapists be sensitive to their own experiencing during the session, be careful to monitor the implicit invitations to join the family members in potentially destructive relational scenarios, reflect on the possible negative and perpetuating effects of her interactions with the family, and explore opportunities to proceed with the session in new and more constructive ways. In our approach the therapist's experiencing is seen as a tool that may be used to further the therapeutic process. This is consonant with the view of family therapists exploring the importance for the therapist of holding open a space of reflection, while it also fits with a dialogical approach to family therapy, in which the therapist's task may be described as listening to the stories the clients tell, and making room for other stories that have not been told before. Two case discussions illustrate our ideas.

Key words: countertransference; family therapy; self of therapist; therapist's emotions.

Introduction

A consistent finding in psychotherapy research is that the quality of the therapeutic alliance is one of the best predictors of psychotherapy outcome (e.g. Bachelor and Horvath, 1999; Martin *et al.*, 2000; Orlinsky *et al.*, 2004): 'Positive therapeutic outcomes are robustly predicted when therapists are experienced as being personally engaged rather than detached, collaborative rather than directive, empathic, and warmly affirming' (Orlinsky and Ronnestad, 2005, p.179). This seems to be true for psychotherapy in general, and for

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family therapy in particular (Blow *et al.*, 2007; Carr, 2005; Sprenkle and Blow, 2004). The question I want to pose in this article, however, is how therapists should deal with strong emotions which they might experience during sessions, especially if at first sight these emotions do not seem to contribute to a positive working alliance. What should therapists do when they experience emotions such as irritation, hopelessness, sadness and fear during the session? I will propose some ideas that address these questions. They deal with the complexity of the therapists' experiencing and their vulnerability during sessions, in such a way that some of the therapists' difficult or ambivalent experiences in therapy can become useful in promoting a collaborative therapeutic dialogue. These ideas may be linked to the views of authors valuing the therapist's experiences in the session, and exploring the importance for the therapist of holding open a space for reflection (e.g. Elkaïm, 1997; Flaskas, 2005; Lerner, 1996, 2004). Furthermore, they fit in with a dialogical approach to family therapy (Rober, 2005b; Seikkula and Olson, 2003) in which the therapist's task may be described as listening to the stories the clients tell us, and making room for other stories that have not been told before. In line with this description of the therapist's task the question we are addressing in this article may be specified as 'how can the experiencing of therapists help them to listen and create room for dialogue?'

The complexity of being a therapist

Pope and Tabachnick (1993) asked 600 randomly selected professional therapists in a survey study about the feelings they have experienced during their work. Over 80 per cent of the respondents reported experiencing fear, anger and sexual feelings in the context of their work. The most widespread feelings were fear and anger, both experienced by 90 per cent of the respondents. This research illustrates that experiencing negative emotions is an inescapable part of the messy and unpredictable process of therapy and should not be considered as a sign of being a bad or inexperienced therapist. In comparison to individual therapy, doing family therapy is probably even more taxing, owing to the extreme complexity of the family therapeutic conversation and its saturation with immediate emotions. Family members come to the therapist because they are in distress, and they are frightened of what the future might hold in store for them. Usually, though not always, one of the parents is more concerned than the other family members, and takes the initiative

to make the appointment. The family members address you, and they tell their stories; afraid as they may be that you might judge or even reject them. They want you to listen to their stories, understand them and believe them, and sometimes they particularly want you not to believe another family member: their partner, their child or their parents, because the other may tell another story; a story that hurts, blames or confuses. It is not easy for therapists to find their place in the whirlpool of suffering, implicit fears and conflicting interests. Of course the therapist is emotionally affected by this encounter that arouses all kinds of troubling feelings: fear, sadness, helplessness, lust, anxiety and so on (Aveline, 2005). Often family therapeutic practice for the therapist is first and foremost a question of how to (emotionally) survive the session (Wilson, 2007). Only then is it a question of how to position oneself in such a way as to be helpful to the family, knowing full well that therapeutic change is an unpredictable event that can be invited and welcomed, but it can never be mastered or controlled. Larner (1998) describes it as follows: 'This is where the therapist stands: outside therapy while inside, and with a sense of humility and astonishment when change occurs' (p. 567).

Several authors in the family therapy field have written about the challenge for therapists in dealing with difficult emotions such as shame (Kavner and McNab, 2005), despair (Flaskas *et al.*, 2007), anger (Rober, 1999), fear (Doan, 1998) and so on. These emotions can be hard to manage for the therapist, and they can become a barrier to the development of a good therapeutic alliance. Sometimes, for instance, such emotions paralyse therapists, as they raise doubts in therapists' minds about their professionalism and therapeutic skills. Furthermore, they can lead to alliance ruptures (Safran *et al.*, 2002). In addition, they may push therapists into dialogical positions that lead to impasses that are not helpful or even destructive for the therapeutic process (Flaskas, 2005; Rober, 1999).

Dialogue and the therapist's inner conversation

There is a long tradition in psychoanalysis of dealing with the experience of the therapist. Countertransference is one of the cornerstone concepts in psychoanalytic theory and practice. Initially, Freud viewed countertransference as an obstacle for therapy, and psychoanalysts were supposed to aim at 'mental neutrality' (Bolas, 1987, p. 201). Later, the view of countertransference changed, as psychoanalysts began to see countertransference as a source of information. Nowadays,

the analyst welcomes information ‘from within himself that is reported through his own intuitions, feelings, passing images, phantasies’ (Bolas, 1987, p. 201). Casement (1991) talks of *communication by impact*, referring to patients who behave in such a way that they stir up feelings in the therapist which could not be expressed in words.

In contrast to the psychoanalytic field, for a long time the family therapy field didn’t give much attention to the therapist’s experiences in the session. Especially after the postmodernist and narrative turn hit the field at the end of the 1980s, the emphasis was on the client’s expertise (Anderson and Goolishian, 1992), and on harmonizing with the client (Smith, 2004). While this was indisputably a very valuable evolution, through the lens of Foucault’s thinking (Foucault, 1979, 1984), the therapist’s contribution to the therapeutic dialogue became suspect, as it has the potential for colonizing clients and robbing them of their own voice (Rober and Seltzer, 2010).

Since the beginning of the new millennium, however, it seems that the person of the family therapist started to reappear in the picture as some authors set out to explore the dialogical character of the family therapeutic meeting (e.g. Andersen, 1995; Rober, 2005b; Seikkula and Olson, 2003), partly based on their study of Bakhtin (1981, 1984; 1986) and Volosinov (1973). Within the framework of these reflections on dialogue and family therapy, several authors suggested that the concept of the therapist’s inner conversation shows promise in addressing the mutuality and shared activity of a therapeutic relationship in the complexity of family therapy practice (e.g. Andersen, 1995; Flaskas, 2005; Lowe, 2004; Rober, 1999, 2002, 2005a). This concept refers to the private dialogues therapists have with themselves while talking with family members. Rather than a guiding principle about what therapists should do or how they should position themselves during the session, the therapist’s inner conversation is a tool that may be drawn on to think and talk about the therapist’s positioning and experiencing in the session, giving access to tacit aspects of the therapist’s self in practice (Rober, 1999, 2002, 2005a).

Up until recently there were only conceptual and clinical publications about the therapist’s inner conversation. We decided to study the concept empirically. Therefore, we studied therapeutic sessions of experienced family therapists from different therapeutic schools with a role-played client¹ (Rober *et al.*, 2008a, 2008b). We used a tape-

¹ This research is described in detail in some of our earlier publications (Rober *et al.*, 2008a, 2008b). Therefore a brief summary of the research will suffice here.

assisted recall procedure to gain access to the therapist's inner conversation (Elliott, 1986; Kagan, 1975), and we conducted a grounded theory analysis on the data (Charmaz, 2006; Strauss and Corbin, 1998). Our basic research question was exploratory in nature and formulated as: 'What is the content of the therapist's inner conversation during the therapeutic session?'

Rather than providing an in-depth discussion of this research of the therapist's inner conversation, we want to focus on some of the findings that are interesting in the context of this article on the therapist's experiencing. What our study primarily showed is that there is a very broad spectrum of thoughts, feelings and ideas on the therapist's mind. This paints a picture of a therapist being present in the session as a complete human being in relation to the client and not just as an information-processing/hypothesis-testing expert, as therapists have sometimes been described in the professional literature (e.g. Martin, 1992; Selvini-Palazzoli *et al.*, 1980).

Another conclusion that may be drawn from the data of our study is that, although therapists tried to influence the therapeutic process in order to be helpful, the therapists were very concerned to be in tune with the client's expectations, preferences and vulnerabilities (Rober *et al.*, 2008a). For instance, they wanted to be in contact with the client's personal process, make room for the client's story and, in particular, they focused on really understanding the client's expectations. Furthermore, the data seem to show that being in tune with the clients was accomplished by the therapist's continuously monitoring and evaluating the client's reactions.

A third conclusion I want to highlight here is that the study pictures listening as an active process. This finding is in line with Bakhtin's ideas about dialogical understanding. According to Bakhtin (1986), understanding is an active, responsive process that originates from participation in conversations. So, for a therapist to understand, a client supposes the active participation of the therapist, and, interestingly, our research gives us some clues about what this active participation might precisely entail. Our study suggests that there are three aspects of the therapist's active listening (Rober *et al.*, 2008b):

1. *Processing the client's story*: This refers to the therapist's processing the content of the client's story about the there-and-then (the world outside the session). The therapist's attention is on the client, and the therapist is listening to the story the client *tells*.

2. *Attending to the client's process:* This refers to the therapist's focusing on, and trying to connect with the personal process of the client in the here-and-now of the session. The therapist is listening to the story the client *shows*. This aspect of listening has been addressed by Andersen (1991, 1992, 1995) who focused in his clinical work on the client's spontaneously occurring bodily activity as manifested in the intonation of words, in pauses, in the client's breathing and so on.
3. *Focusing on the therapist's own experience:* This refers to the therapist as a living human being in the here-and-now of the session. The therapist's attention is on his own experiencing. The therapist is listening to the story the client invites him to experience.

In the context of this article on the therapist's experiencing the second and especially the third level is of interest to us. These levels refer to the therapist's listening to what escapes words: the unsaid and the unsayable (Frosh, 2004). Therefore these levels may be linked to some of the traditional writings on the psychotherapeutic encounter, such as psychodynamically inspired publications on countertransference and projective identification (e.g. Flaskas, 2002; Skynner, 1987). It may be less obvious but these levels may also be linked to publications highlighting the importance of silence in the expression of suffering (e.g. Charmaz, 1999, 2002; Compare, 2007; Pearlman and Saakvitne, 1995; Scott and Lester, 1998). Charmaz (1999), for instance, studied the stories of patients suffering from chronic illnesses, and found that telling their stories raises risks for these patients. For them, not speaking is 'a strategy to keep both suffering and story from becoming real' (Charmaz, 1999, p. 373). She states that the language of pain often remains implicit. It is not possible for patients suffering from a serious illness to express the raw experience of their suffering in words: the worst suffering is expressed non-verbally or through silences (Charmaz, 2002). Authors who have studied trauma in families maintain that what is really hard to express for trauma survivors is often kept silent, but may be evoked in the therapist's experience: 'Survivor clients are often unaware of their affective experiences, so that we as therapists, are often first aware of our client's feelings through our own' (Pearlman and Saakvitne, 1995, p. 23). That is why some authors from the trauma literature consider the therapist's experiencing as a tool for understanding (Pearlman and Saakvitne, 1995): What is evoked in the therapist's experiencing are the parts of the client's story that cannot be expressed otherwise.

There have also been publications in the family therapy field in which the therapist's experiencing in the therapy session is valued as a tool for understanding and dialogue (e.g. Andolfi *et al.*, 1989; Flaskas, 2002; Haber, 1990, 1994; Real, 1990; Whitaker and Keith, 1981). Elkaïm (1997), for instance, proposes a systemic view of the therapist's feelings, stating that the first tool of the therapist is the therapist's self. So for Elkaïm the therapist should not try to avoid experiencing, but rather 'use it as the heart of the therapy' (Elkaïm, 1997, p. 170). Elkaïm stresses the importance of the context in which the therapist's feelings arise. According to him, what therapists experience during sessions not only comes from their personal history, but is also amplified and maintained by the dialogical context. Speaking from a systemic/cybernetic perspective he states that the importance of the therapist's personal experience lies in its meaning and function for the therapeutic system. In addition, Hoffman (2002) explores the therapist's experiencing as a tool when she writes about 'travelling empathy', or 'tempathy' for short. Tempathy refers to a kind of transpersonal communication that is often reflected in the images, ideas or considerations that can pop up in therapists' inner conversations while they are talking to family members (Hoffman, 2002). Elkaïm and Hoffman suggest that therapists know more than they can say (Frosh, 2004). They propose that therapists would allow themselves to go beyond their technical-rationality, and use their implicit, experiential knowing to connect with what is –as yet – unsayable for the client. They suggest that in that way they can develop a richer understanding of the stories their clients present to them.

The therapist's experiencing as a tool

The reflections of Elkaïm and others about the therapist's experiencing as a tool, added to the findings of our research on the therapist's inner conversation, highlight the value of the therapist's experiencing during the session, and the need for therapists to reflect on their experiencing during the session. I will introduce a case vignette of Johnny (pseudonym) and his mother that will be the starting point for the development of some ideas about the therapist's experiencing in the family session. First, however, I want to emphasize that the case vignette of Johnny and his mother is offered in the form of a transcript in two columns (Table 1). The first column is the literal transcript of the conversation between the family members and the therapist. The second column is a depiction of the therapist's inner

Table 1 *Transcript*

Outer conversation (OC)		Therapist's inner conversation (TIC)	
OC 1	Mother is crying silently.		
OC 2	Johnny addresses the therapist, and smiles: 'I hate her, and if she keeps messing with me I will kill her.'	TIC 1	I feel a flash of fear going through me - he sounds so cold. Would he really do that, I wonder. Kill her? At the start of the session the mother mentioned that she was afraid of her son. Is he really threatening to kill his mother?
OC 3	Mother is crying harder now.	TIC 2	I feel sadness coming on and I want to comfort her.
OC 4	Therapist hands her the box of Kleenex.		
OC 5	She takes a tissue.	TIC 3	I think that it's not up to me to comfort the mother. I should invite her to talk instead.
OC 6	Therapist asks her: 'If your tears could talk, what would they tell us?'		
OC 7	Mother answers: 'I do not deserve this. I have always loved him and taken care for him. I have given him whatever he needed. And now he bullies me and he wants to scare me.'	TIC 4	In some way this answer reassures me. He wanted to scare her, but he didn't want to kill her. And then I realize that he had scared me too, and that I had turned to the mother for comfort. My comfort.

conversation. The inner conversation in this transcript was reconstructed using a tape-assisted recall procedure (Elliott, 1986; Kagan, 1975). The procedure used for this transcript followed two steps. First, the session with the family was recorded on videotape. Second, immediately after the session, the therapist watched the videotape. As in the classical tape-assisted recall research procedures the therapist stopped the tape whenever he could remember things he felt, thought, or experienced at that moment in the session. The therapist made notes of these reflections. These notes were then combined with the transcribed videotape, resulting in a transcript in two columns: one column with a transcription of the outer conversation between the therapist and the family, and one column with the therapist's inner conversation.

The case of Johnny and his mother

Johnny is a 14-year-old boy referred by the juvenile court because of extreme violent behavior. We are some twenty minutes into the first session with Johnny and his mother.

In the therapist's inner conversation, we can see the therapist struggling with what happens in the session, and with what it evokes in him in terms of emotions and dilemmas. The therapist is trying to make sense out of what happens and he is reflecting on how he should handle the situation as a therapist: should he comfort the mother, or should he rather make room for her to talk about her experiences? Let us now look more closely at the therapist's experiencing in the case vignette of Johnny and his mother.

Reflections on the therapist's experiencing

In this brief vignette, we notice that the therapist feels two emotions most prominently (sadness and fear). Let us first focus on the therapist's experience of sadness (TIC 2). This seems to be evoked by the mother's crying (OC 3). Interestingly, the experience of sadness invites the therapist to comfort the mother (TIC 2). This illustrates how as action potentials (cf. the Latin *emovere*, where *e* or *ex* means *out*, and *movere* means *move*) emotions are invitations to act. They tempt us to take part in emotional scenarios (Gergen, 1999). It is as if emotions encourage us (sometimes they even *urge us*) to act out a culturally scripted part in a dialogical play. This is also true in therapy: the therapist's experiencing also invites him to do something in the

encounter with the family members. Often the therapist is recruited to play a role in the enactment of the family drama (Wilson, 2007). In the vignette, we notice the therapist jumping in rather impulsively to offer the mother the box of Kleenex (OC 4). The question poses if this relational scenario that is played out in the session (*mother weeping/therapist comforting*) is constructive. It could be argued that the therapist handing the mother the box of Kleenex models an important behaviour for Johnny, or that it is an honest expression of concern. On the other hand, it could be argued too that it is potentially a dangerous scenario because being reactive in this way positions the therapist as comforter, mother as victim and Johnny as perpetrator. Such a positioning may be experienced as blaming by Johnny: he is excluded from the positive interaction between mother and therapist, and implicitly labelled as the bad guy. Furthermore, while the position of the therapist as comforter might be comfortable for the therapist and for mother, it could be considered as problematic, as it might discourage comforting reactions from other family members in the session (Johnny), or from members of the mother's social support system who are not present in the session, but who might respond to the mother's weeping after the session. If the therapist dries the mother's tears, it may rob somebody else from the occasion to comfort her.

The question may be posed what the therapist could have done instead of offering the box of Kleenex to the mother. Judging from the therapist's reflections in his inner conversation (TIC 3), he himself considered his impulsive comforting reaction to be in need of correction. He describes his therapeutic role as inviting the client to talk (TIC 3), rather than as actively intervening in the family and its management of emotions. He decided to correct it, and tried to open up space for the mother to talk about her tears and her sadness by asking her 'If your tears could talk, what would they tell us?' (OC 6).

Summarizing, this is what we see happening in the vignette around the therapist's experience of sadness: the therapist feels sadness, he offers the box of Kleenex, then he reflects and corrects his position by asking the mother, 'If your tears could talk, what would they tell us?'

It is important to point out that sadness was only one to the therapist's emotions mentioned in the transcript. There is also a second emotion invoked in the therapist in the brief sequence under consideration: fear (TIC 1). This emotion seems to be evoked by Johnny's threatening remark '*I will kill her*' (OC 2). The therapist is not only struck by the content of the remark, but also by the coldness of

Johnny's expression. He reacts with a flash of fear (TIC 1). This suggests that he is surprised and overcome by a rush of strong emotion. In his inner conversation he starts to weigh the risk of homicide. These reflections seem to reassure him somewhat, as they push back the inner voices expressing fear, and help him to focus on the mother's sadness. Apparently the emotion of fear was contained by the therapist, and did not invite the therapist into any relational scenario. However, at the end of the transcript the therapist realized that he had been caught up in a relational scenario after all (TIC 4): for his own comfort he had been seeking the reassurance from the mother that there was no real threat. So it seems that while on one level he was trying to comfort the mother, on another level he was seeking comfort with the mother.

This highlights the complexity of dialogues as well as the danger of being reactive in unreflective ways. In fact, it suggests that the therapist acted on his emotion rather impulsively, and became involved in an interaction with the family members that might be considered non-therapeutic or even exploiting and unethical. It could also be argued that a correction of the therapist's inclinations was warranted, and the question can be posed if it would not have been possible for the therapist to use his experiencing (his fear) as an opening of dialogical space. Without such a correction, as is illustrated in the transcript, there is the danger of acting out his emotion (fear) in the session, and the risk of becoming involved in perpetuating destructive interactions with the family. Furthermore, the chance is missed to open up space for dialogue about fear and how it impacts on their lives. In the vignette of Johnny and his mother, the full danger of these perpetuating interactions became apparent later in the session when the mother told the therapist that she sometimes felt used by Johnny's occasional appeals for her comfort. She felt that she could not resist these appeals for comfort because at least it offered her the opportunity to occasionally feel like a good and supportive mother. Only later it made her feel used and exploited too, because she realized that a few days later Johnny might become abusive again.

Three concepts

When we look at our reflections on the vignette of the case of Johnny and his mother (Table 1), three concepts stand out: the therapist's experiencing, invitation to act, and opportunity to dialogue.

1. *The therapist's experiencing*: This has to do with what is going through the mind of the therapist. What is the therapist feeling? What are the therapist's intentions? What are the emotions he is struggling with? What are the dilemmas he is facing? What are the fantasies he is dealing with? And so on. The therapist's experiencing – in this context – is broader than just the therapist's feelings. For instance, some of the therapist's internal judgements may also be of interest here: the idea of moving too fast or too slow, of pushing too hard or backing off too quickly and so on.
2. *The invitation to act*: An emotion is considered as an invitation to take part in a relational scenario, and to adopt a certain position in such a scenario (Gergen, 1999). In order to reflect on the therapist's position in the family therapeutic encounter, these are some important questions to consider: What exactly is it that the therapist is tempted to do? Which part is he inclined to play in the dialogical context of the session? As these relational scenarios in which the therapist is invited to play a role can sometimes be destructive because they perpetuate unhealthy or pathologizing interactions between the family members (Flaskas, 2005), it is also important for the therapist to ask himself if it would be helpful for the family if the therapist would play that part in the scenario. Would it open up space for things unsaid? Would it create opportunities for renewed connections between family members? And so on.
3. *The opportunity to dialogue*: This concerns the question how the therapist's experiencing can be usefully introduced into the dialogue as a therapeutic opportunity. Is it possible to introduce something of the therapist's experiencing into the session in another way than to just act it out in a possibly destructive relational play? How can the therapist's experiencing inspire his questions in such a way that the destructive scenario that lies in wait is avoided, and dialogical space for the not-yet-said is opened up instead? Especially in cases of therapeutic impasse this may involve a lot of reflective work on the part of the therapist as he has to find constructive ways to think about the family instead of the pejorative and rejecting thoughts that are occupying him in this gridlocked situation (Flaskas, 2005; Lowe, 2004; Rober, 2002). Through these reflections a renewed curiosity can develop in the therapist, leading to a fresh empathic connection with the family members and reopening space for rich and surprising dialogues.

These three concepts (the therapist's experiencing, invitation to act, opportunity to dialogue) may be seen as three steps in the therapist's reflections on his experiencing in the session. Let us illustrate this with a case story.

The Janssens family

The case story

The Janssens family consisted of a divorced mother and two sons, Arnold (19 years old) and Frank (21 years old) (Figure 1). The mother was depressed and disappointed after she had divorced her husband three years previously. Her husband was a rich diplomat who was on the one hand very strict with the children, but on the other hand he spoiled them materially. After the divorce he was given a new position in the Belgian embassy in an Asian country. There he had met another woman and, after some time, he had married her and started a new family.

In the first session, the mother talked about her worries concerning her sons. She said that, although they were very open and charming towards the outside world, within the family they did whatever they pleased. They refused to help their mother in any way in the house. They took no responsibility, doing whatever caught their momentary fancy and asking for their mother's financial help whenever they

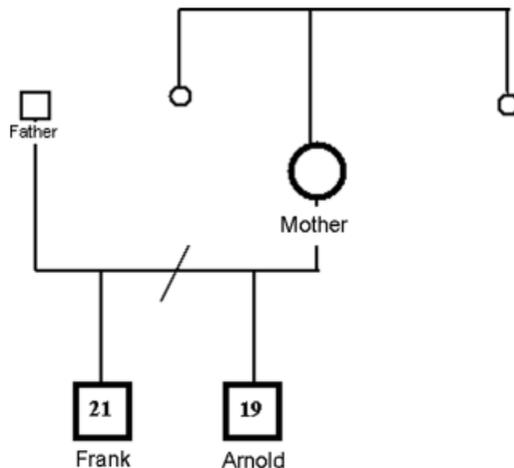


Figure 1: Genogram of the Janssens family

needed something. When their mother said no, or tried to be stricter with them, they became aggressive and verbally abused her. The mother did not feel respected by them. To give one example: Frank used his mother's car all the time. She had to ask for his permission when she wanted to use her own car. In addition, Frank often drove too fast and got a lot of speeding tickets. However, since it was his mother's car, the speeding tickets were filled out in her name. In order to protect her son, she did not correct this with the police. One day she had to go to court because she had received more than three speeding tickets in one month. The judge reproached her for reckless driving and took away her driving licence for several weeks.

When I heard the stories about what had happened between the mother and her sons, I felt myself protesting. This was not fair. While on the surface it seemed that I further explored this issue with the mother, implicitly I began to gently push her into being more assertive and strict towards her sons. After a while I invited her to speak firmly to her sons here and now in the session about her wanting to be respected by them and that she expected them to help in the household. Reluctantly, she tried it out and spoke to the boys. The sons reacted by smiling, and answered her in a charming way that they had all kinds of good reasons not to take any responsibility and to do whatever they pleased. Her sons made some joking remarks and their charm made their mother's heart melt; she gave in, started to make jokes too, and became softer again. The sons had won. I talked to the three of them about my observations, and then again invited the mother to try once more to be stronger. Indeed, now she sounded a little more assertive, but then all of a sudden Frank started to reproach her for his father leaving (*'Now I understand why my father left you . . .'* and so on). His voice sounded threatening and hard; it was no joke any more. I saw that the mother was hurt by Frank's words. She sank down into her chair, her shoulders dropping. At once she looked beaten and depressed. I noticed myself thinking, 'How cruel these children are towards their mother', 'These children are spoiled', and 'They don't care about their mother'. In a flash I also fantasized that I would take the children to see a psychiatrist. They needed to have a diagnostic evaluation and probably medication, I fantasized. The session ended with the children saying that they would not come to the next session because they had more important things to do. After all, Frank added, it all was their mother's problem 'because she is over-sensitive and can't take a joke'. 'She needs therapy,' he concluded, 'not us.'

After the session I felt very bad about how the session had turned out and I took some time to reflect on what had happened. In my mind's eye I reviewed the session, and I was surprised about my pushing the mother – gentle and implicit as it was – into being more assertive. I explored my own experiencing and realized that in fact I was outraged about how the children had acted towards their mother and that this invited me to be protective towards the mother, and to put pressure on the boys. At the same time I had been irritated by the mother's resignation and passivity. This had all resulted in my urging the mother to act firmly. As this had proved useless, I finally felt powerless and beaten. Gradually I became aware of how pejorative and even rejecting my own thoughts about this family in the process had become. I understood that I had to find a more constructive way to look at this family. I focused on the mother and realized that her resignation was probably the expression of the impotence she felt as a mother after all her vain attempts to bring about change in her family, and to make her sons respect her. Luckily, I also realized that my feeling of impotence could be an empathic bridge towards the mother.

The mother came alone to the second session. She had tried to convince her sons to join her, but they had refused to come. We talked, and I apologized that the previous session went as it did. I also explained that I had misinterpreted her passivity as resignation, but that I now understood that it was a wise way to deal with a situation in which she felt powerless. The mother agreed and let out a big sigh. It was as if she was relieved by my words. I explained that I had not given enough attention to her worries about the children and to all the efforts she had made to get them to behave in a more responsible and supportive way. I talked about my own feeling of impotence the previous session, and I said, 'In fact we are united here in our impotence'. She agreed.

I invited her to talk about how she had tried to get the family back on the right track.

She started to talk about her commitment to her children and her love for them. She emphasized her worries about their future if they continued to refuse to take any responsibility. She talked about the lack of respect of the children and about her protests that didn't amount to anything.

I asked her who else in her context might understand her powerlessness. She replied: 'My sisters.'

We talked about her sisters. In previous years they had also tried to help her to be more assertive and strict so that her sons would respect

her, but to no avail. At the end of the session I proposed that she invite her sisters to the next session to talk about this powerlessness. She agreed that it was a good idea to talk with her sisters. She promised to contact them.

The three sisters attended the next session. I reminded them that we were united in powerlessness, and that at least *I* – perhaps they disagreed – did not see how we could talk some sense into the sons. Everybody agreed and we talked about the family, their history and their family of origin. The main themes were love and powerlessness. At the end of the session I asked the three sisters if this conversation had been helpful for them. Yes, they said, and the mother added that she was very grateful to her sisters for supporting her. Then she addressed me and thanked me for giving her the opportunity to talk about her difficulties with her sisters.

I had two more such conversations with the three sisters. We talked about how the boys can sometimes be very threatening, and about how humiliating it is to feel impotent and small in the face of one's own children. The mother shared her anger towards her ex-husband who had abandoned her, and she said that, if it were not for her children, she regretted she had ever met him. Interestingly, at a certain moment an unexpected new story emerged. One of the mother's sisters talked about the sons' powerlessness. She told how Frank had once confided in her in tears that he missed his father and how he felt abandoned by him. He told her that, without his mother knowing it, he had phoned his father several times in Asia to try to persuade him to return to the family. At first his father had said he would think about it, but a few weeks later his father phoned back to announce that he had married again, and that his young wife was expecting a baby. 'I will never be weak again,' Frank had confided to his aunt. 'Nobody will ever hurt me again like that.'

Reflections on the therapist's experiencing

When we approach the case of the Janssens family using the three concepts we developed above (the therapist's experiencing, invitation to act, opportunity to dialogue) we can summarize the evolution the therapist's position in the sessions with the Janssens family in Table 2.

Focusing on the therapist's experiencing, it is clear that the stories of the boys outraged the therapist and made him feel protective towards the mother. Focused on the mother's passivity, he did not acknowledge her attempts to bring about change, or her powerlessness;

Table 2 Reflecting on the therapist's experiencing in the case of the Janssens family

<i>the therapist's experiencing</i>	outrage, feeling protective, powerlessness
<i>invitation to act</i>	(<i>first</i>)working hard, pushing for change, (<i>ultimately</i>) mounting frustration, impotence, blaming ("spoiled, . . ."), fantasising about calling a psychiatrist in for diagnosis and medication . . .
<i>opportunity to dialogue</i>	making room to talk about powerlessness, and about everything mother has tried to bring change. Creating space for mother to talk with her sisters who also feel powerless.

neither was he aware of his own impotence. Instead, the therapist felt invited to take a strong position in the session, modelling what he expected the mother to do. Some might say that the therapist took the place of the absent father; filling the gap the father had left when he went to Asia. Perhaps this is true, but anyway, the therapist pushed the mother to act, thereby again putting her through the depressing experience of being ignored, threatened and humiliated by her sons.

When after the first session the therapist took time to reflect on his experiencing in the session, he realized that he was involved in a destructive scenario with the family; labelling the mother as the victim and protecting her, while blaming the sons. At the same time he realized he felt more and more powerless. He recognized the opportunity his experiencing presented and understood that his feelings of powerlessness could serve as an empathic bridge between himself and the mother. Later, in the second session, he even saw the opportunity to use the feeling of powerlessness as a bridge between the mother and her social support system (her sisters).

Discussion

While outcome studies consistently highlight the importance of the therapeutic relationship, the family therapy field does not offer many conceptual resources to practitioners to talk and reflect about the complexity of family therapy practice, and in particular about their own experiencing in the session. The field proposes some general principles prescribing how the therapist should position himself in the session with the family, such as neutrality (Selvini-Palazzoli *et al.*, 1980), curiosity (Cecchin, 1987), and not-knowing (Anderson and Goolishian, 1992). These general principles have their merits as they

give therapists something to hold on to, but they insufficiently value the therapist's here-and-now experiencing in the session, and they fall short of meaningfully addressing the full complication of the relational processes of a family therapeutic session in practice in a satisfactory way. It is remarkable that family therapists like Whitaker (Whitaker and Keith, 1981), Elkaim (1997) and Andolfi (Andolfi *et al.*, 1989), who tried to meaningfully connect the experiencing of the therapist with the complex dynamics of the family therapeutic encounter, seem to have fallen out of grace in the field when the postmodern perspective became dominant. The approach presented in this article reconnects with the ideas of these authors and proposes that the therapist would be sensitive to his own experiencing during the session, take care to monitor the implicit invitations to join the family members in potentially destructive relational scenarios, reflect on the possible negative and perpetuating effects of his interactions with the family, and explore opportunities to proceed with the session in new and more constructive ways.

However, being sensitive to our own experiencing is no simple matter. In both of the clinical examples we have presented the therapist did not acknowledge part of his experiencing, and acted impulsively on his emotion. In the vignette of Johnny and his mother the therapist acted on his fear without acknowledging it, and in the case of the Janssens family the therapist rushed into pushing for change without acknowledging his powerlessness. Clinical experience has taught us that experiences that are not acknowledged by therapists often get them into trouble. Conversely, acknowledging experiences is sometimes tough, as it also means being aware of these experiences, to bear them and to tolerate them. According to Frosh (2004), dealing with the unsaid and the unsayable is frightening for therapists as clients appear as *others* (Larner, 2004) or as *strangers* (Kristeva, 1991), while at the same time they demand something from the therapist. This can evoke feelings of impotence and helplessness in the therapist. It may also stir up the issue of feeling like an impostor (Clance and Imes, 1978; Sightler, and Wilson, 2001), as it can give rise to therapists' secret fear that they are not worthy of their position as therapists: 'When clients say, "help me, cure me, reach me," what on earth do they want? And why, especially, do they want it from me?' (Frosh, 2004, p. 60). Acting impulsively may be our way of protecting ourselves: keeping strangeness at bay and avoiding being really aware of the confusing things we are feeling. That is why carefully reflecting on one's own experiencing and positioning during the session is

important. It is however not always possible to find the time and space to really reflect on these things during the session. Taking time after the session to think over what happened, or even better, to talk with colleagues or with a supervisor about the session, is no luxury, but rather a necessity. During such reflections the three concepts we introduced in this article (the therapist's experiencing, invitation to act and opportunity to dialogue) can be useful tools for therapists to help them if necessary to correct their positioning in the dialogue. These concepts can assist therapists in finding ways in which their experiencing can open up space for new and enriching dialogues with family members, between family members, and between family members and their social context.

Conclusion

The approach introduced in this article may be seen as a way to address the complexity of the family therapist's position in the session – 'outside therapy while inside' (Larner, 1998). Anytime during the course of a session, and especially when the family therapist feels stuck, it is important for the therapist to give attention to his own process and reflect on the way it might be intersecting with what is happening in the session. We proposed the three concepts that may be useful as tools to help therapists to reflect on their experiencing in the session: the therapist's experiencing, the invitation to act and the opportunity to dialogue. These three concepts may be seen as representing three steps in a process of reflection:

Step 1. The therapist is sensitive to his own experiencing during the session.

Step 2. The therapist considers his experiencing as implicit invitations to join the family members in relational scenarios, and reflects on the possible negative and perpetuating effects of these scenarios.

Step 3. The therapist explores dialogical opportunities to use his experiencing to proceed with the session in new and constructive ways.

The approach to the therapist's reflecting proposed in this article refers to the kind of questioning seasoned therapists ask themselves in the course of a session, and that younger and new therapists reflect upon with their supervisors. Although the usefulness and validity of these concepts need further study, they show promise in aiding therapists to develop a higher threshold for reactivity in the session,

especially in those moments when they are experiencing intense emotions that implicitly but urgently invite them to act. Acting automatically without a moment for reflection can be hazardous for the therapeutic process. The approach presented here may be considered to be a potential path for therapists to prevent them from becoming involved in destructive scenarios with families leading to perpetuating vicious interactions and impasse, potentially resulting in therapy failures or premature termination.

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