The Therapist’s Inner Conversation in Family Therapy Practice:

Struggling with the complexities of therapeutic encounters with families

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Therapists engaging in conversations with families find themselves in highly complicated situations. As a rule, the therapist meeting family members for the first time encounters a group of distressed people apprehensive about what the future has in store for them. Some family members arrive willingly, others less so. Usually, though not always, one parent is more concerned than other family members and has taken the initiative to contact the therapist. As the sessions proceed, family members tell their stories - some with a lot of hesitations, others less so. Often, they seem fearful of being judged and - worst of all - being rejected by the therapist. All want the therapist to listen to their stories and to understand and believe them. It is no easy task for therapists trying to find their footings in the complexities brought into the therapy room by the family. The key question they have to address in these encounters is one involving how best to navigate and to negotiate in the shifting currents of interests, fears and suffering in the family. Furthermore, therapeutic change adds to the
complexities of the situation since such an event though invited and welcomed can never be predicted, mastered and controlled (Larner, 1998).

Family therapy practitioners have few conceptual resources at their disposal to talk and reflect about the complexity of family therapy practice. They often have to rely on general principles about the therapist’s stance, such as neutrality (Selvini, Boscolo, Cecchin & Prata, 1980), curiosity (Cecchin, 1987), not-knowing (Anderson & Goolishian, 1992). These principles give something to hold on to, but they fail to address the full complication of the relational processes of a family therapeutic encounter in practice in a satisfactory way (e.g. Flaskas & Perlesz, 1996; Flaskas, Mason & Perlesz, 2005). According to some authors the concept of the therapist’s inner conversation shows more promise than these general principles and guidelines, as it addresses the mutuality and shared activity of a therapeutic relationship in the complexity of family therapy practice (e.g. Andersen, 1995; Rober, 1999, 2005; Flaskas, 2005; Lowe, 2004). In this article I will talk from my experience as a family therapist. For reasons of space limitations, I will only sparsely refer to authors from the person centered and existential approaches who have covered some of the same territory as I am covering in this article (e.g. Schmid & Mearns, 2006; Cooper, Mearns, Stiles, Warner & Elliott, 2004; Behr, 2003), and limit myself mainly to references to literature from the family therapy field. I will first outline the frame of a dialogical perspective on family therapy, in order to later focus on the contribution that the concept of the therapist’s inner conversation might have in addressing issues of the person of the therapist in practice, and especially in addressing the complexity of what it means to be a family therapist in practice. In the last part of the article, I will present a case story that illustrates how the concept of the therapist’s inner conversation can help practitioners to talk and reflect about some of their experienced, but unnoticed experiences in therapy practice.
The therapist and the postmodernist turn

The postmodernist and narrative turn hit the family therapy field at the end of the 80’s, and swept across the field in the 90’s. The representational nature of knowledge, the idea that knowledge is some kind of representation of a real world out there, was challenged. Knowledge, even scientific knowledge, could no longer be accepted as the truth because there is no objective reference point from which to observe the world. More than an epistemological evolution, the postmodernist and narrative turn made a lot of family therapists take a fundamental ethical position: Therapeutic conversation was to be a dialogue in which a therapeutic relationship of participation and collaboration was favored. This choice for dialogue was at the same time a choice against a technical, hierarchical, or interventionist therapeutic relationship that dominated the field for years (for instance, in the form of structural and Milanese family therapy). Since the 90’s the family therapy field favors a therapeutic relation of collaboration (Anderson, 1997), participation (Hoffman, 1991) and co-authorship (White, 1991).

In this context, the person of the therapist became an ethical problem. Inspired by the writings of Michel Foucault (1979, 1984), the therapist, especially his/her knowledge and expertise, is seen as potentially repressive and colonialising. Foucault states that knowledge and power (pouvoir-savoir) are intertwined (Foucault, 1979). Power functions through normalizing knowledge or truths. These truths are norms that give order and form to people’s lives. People submit to these normalizing truths by measuring themselves and people around them in relation to these norms, by evaluating their lives in the light of this dominant knowledge (Foucault, 1979). Especially sciences like psychiatry, psychology, criminology, and so on produce this normalizing knowledge. These sciences have become judges of
normality as they "...characterize, classify, specialize; they distribute along a scale, around a norm, hierarchize individuals in relation to one another, and if necessary, disqualify and invalidate…" (Foucault, 1979, p. 223)

How can a therapist have a collaborative relationship with clients if a therapist is an expert with expert knowledge? How can a therapist be assisted to resist the temptations of power and hubris (Amundson, Stewart & Valentine, 1993)? In an attempt to give an answer to this ethical dilemma, the concept of not knowing was introduced by Anderson and Goolishian (1988, 1992). Not knowing refers to a stance in which the therapist communicates a genuine curiosity for the client’s story. The therapist does not know a priori, but listens to the client’s story, takes the client’s story seriously and joins with the client in a collaborative exploration of his/her experiences: “Not-knowing requires that our understandings, explanations, and interpretations in therapy not be limited by prior experiences or theoretically formed truths” (Anderson & Goolishian, 1992, p. 28). The concept of not knowing puts the spotlight on the client’s expertise, and invites the therapist to be critical towards his/her self. According to postmodernist family therapists, the therapist has to acknowledge the dangers of his/her expert knowledge, and be accountable for his/her prejudices and biases.

**Knowledge of the third kind**

Highlighting the importance of the client’s expertise and distrusting the therapist knowledge might make us forget that the therapist’s contribution to the family therapeutic session is only partly intentional, and that the expertise of the therapist is only partly of the theoretical kind. This was pointed out by family therapists who maintained that in the practice of therapy another kind of knowledge is more important (Andersen, 1995; Katz & Shotter, 2004), an embodied kind of knowledge, that Shotter (1993) calls knowledge of the third kind - the knowledge of the first kind being a representational knowledge of a theoretical kind (knowing
that), and the knowledge of the second kind a technical knowledge of a skill or a craft (knowing how). This is knowledge of the third kind has to do with our anticipations and expectations in social situations, as well as with the arsenal of potential responses and reactions we have at our disposition. It is like two dancers who move together with nicely coordinated movements. Without really knowing (in a representational sense) what will happen, they anticipate each other’s movements and respond to each other with new movements. This is a kind of embodied knowledge, “in terms of which people are able to influence each other in their being, rather than just in their intellects; that is, to actually ‘move’ them rather than just ‘giving them ideas’” (Shotter, 1993, p.40–41). It is implicit knowledge, in the sense that it does not presuppose conscious reflection or deliberation, nor can it be articulated by the individual. Nonetheless, it can be observed in a person’s everyday social practices, as he/she coordinates his/her actions with others. It is a knowledge from within our relationships with others, and it determines what we anticipate or expect will happen next. In contrast to the other two kinds of knowledge (knowing that and knowing how) through this third kind of knowledge we do not experience ourselves as individuals. Instead, we feel ourselves to be involved and enabled to participate in a social situation and be responsive to it. This kind of knowledge becomes visible only in the process of our interaction with others; thus can only be studied in the brief interactive moments that make out our daily social live (Shotter, 1993).

The importance of this knowledge of the third kind to the practice of family therapy becomes evident when we observe a family therapist working with a family. We notice that although the theoretical and technical knowledge of the therapist plays some part in his/her decisions, his/her actions and his/her interventions, many of the therapist’s actions can only be understood if we focus on the way the therapist’s and the family members’ actions are coordinated in a collaborative dance. In the continuous flow of words and actions we can
distinguish the therapist’s words and actions, as reactions not only to the family members’ words and action, but also to anticipated or potential actions and words. In the same way, family members react to each other’s words and to the therapist’s words, but also to words that were spoken before, as well as to words that were never spoken but only anticipated. In this way therapy presents itself as a dynamic, embodied process in which the participants, each in their own way, are responding to each other—“move” each other, as Shotter would say—and in which together they shape the therapeutic conversation.

**Knowing in action**

The family therapist’s actions in the stream of the conversation, resulting from unreflected and immediate responding to what presently happens in the session, is referred to by some authors as actions from a *default position* (Reimers, 2006). Given the complexity of a family therapeutic session, it seems unavoidable that the therapist’s contribution to the dialogue is some kind of balance of conscious therapeutic intent and a default position. Although it is important to be available to the uniqueness of the therapeutic conversation, action from a default position does not have to be problematic because, as the well-known research of Donald Schön (1983) on practitioner's knowledge illustrates, a lot of wisdom is present in our intuitive actions. Schön studied practitioners in action (psychologists, engineers, architects, etc.). He found that good practitioners rely less on the systematic knowledge they learned at the university (what he calls 'technical rationality'), and more on some kind of improvisation learned in practice. In practice, professional situations are characterized by complexity, uncertainty, instability that necessitates another kind of knowledge. This kind of knowledge Schön calls *knowing-in-action*. This *know-how* does not rest on rules and plans that are entertained prior to action, nor can a practitioner articulate why he/she acted like he/she did. Although practitioners sometimes make conscious use of scientific theories, most of the time
they are dependent on tacit recognitions, choices and judgments. As Schön (1983) writes: "…
skillful action often reveals a 'knowing more than we can say'" (p. 51). Kvale (1992) notices
that this description of professional practice given by Schön comes "close to Lyotard's
analysis of postmodern knowledge as incomplete, discontinuous and paradoxical, and where
judgments are past without explicit criteria for the judgment." (p.50) Indeed, the knowledge of
practitioners is in line with postmodern ideas of knowledge as foundationless, fragmentary
and with practical utility as criterion of validity (Kvale, 1992; Polkinghorne, 1992). Given
this emphasis on practice the challenge for a family therapist becomes: How can I act in ways
that encourage new resources for action? Indeed, family therapy is not about philosophical
abstraction or psychological theorizing: "It is about actions of persons in relation." (McNamee, 2000, p.180) Family therapy is a form of practice: "The attempt is not simply to
'say things differently' and thereby declare 'the way it is.' Rather, the attempt is to engage
others … in activities that broaden our resources for social life." (McNamee, 2000, p.181).

The therapist’s inner conversation

Since the passing of the millennium, a dialogical perspective is emerging in the family therapy
field (e.g. Seikkula, 2002; Seikkula & Olson, 2003; Guilfoyle, 2003; Rober, 2002; 2004,
2005) as it is in individual work within the PCE therapies (Cooper, Mears, Stiles, Warner &
Elliott (2004). Within this view, some family therapists have described the therapist’s self as
an inner dialogue (e.g. Anderson & Goolishian, 1988; Penn & Frankfurter, 1994; Andersen,
1995; Rober, 1999; 2002; 2005). The therapist maintains an inner dialogue with him/herself,
which is the starting point of his/her questions. This dialogical conversation has been called the
therapist's inner conversation (Rober, 2002; 2005).
While the concept of *not-knowing* focuses on the therapist’s knowledge as the central issue (Anderson, 2005), the concept of the therapist’s inner conversation refers to a broader spectrum. It refers to whatever the therapist experiences, thinks, feels, but does not share in the session - what is not (yet) said, or shown by the therapist. The concept of the therapist’s inner conversation is inspired by Mikhail Bakhtin’s concept of the dialogical self as a polyphony of inner voices (Bakhtin, 1981, 1984; Morson & Emerson, 1990; Hermans, 2004a, 2004b). Referring to William James’ classical distinction between the *I* and the *Me* (James, 1890), this dialogical self can be portrayed as a multiplicity of I-positions (Cooper, 2004; Hermans, 2004a, 2004b): It is “a dynamic multiplicity of (voiced) positions in the landscape of the mind, intertwined as this mind is with the minds of other people.” (Hermans, 2004a, p.176).

Hermans (2004b) describes the self in spatial terms: “…self as being composed of a variety of spatial positions and as related to positions of other selves” (p.18) According to Hermans the I moves from position to position, as in a space, depending on the context: “The I fluctuates among different and even opposed positions. The voices function like interacting characters in a story. Once a character is set in motion in a story, the character takes on a life of its own and thus assumes a certain narrative necessity.” (Hermans, 2004b, p.19)

Based on our clinical and training work, we differentiated the therapist’s inner voices, by making a distinction between voices reflecting the therapist’s experiencing self -and voices reflecting his/her professional self (Rober, 1999):

1. **The experiencing self**: These are the observations of the therapist as well as the memories, images, and fantasies that are activated by what the therapist observes. This is closely akin to what Bakhtin terms the *I-for-myself* (Morson & Emerson, 1990). As I-for-myself the therapist mainly senses him/herself as acting in response to the context, and to the invitations of the clients. In a sense, the experiencing self implies a
not-knowing receptivity towards the stories of the client, as well as towards what is evoked by these stories in the therapist.

2. The professional self: This is the therapist’s hypothesizing (Rober, 2002) and his/her preparing of responses. From an observer position towards the experiencing self, the therapist tries to make sense of his/her experiences by structuring his/her observations and trying to understand what is going on in the family and in the conversation. A Bakhtinian term for this would be the I-for-others (Morson & Emerson, 1990), because it is as if the therapist observes him/herself from the outside, as if he/she is watching a play in a theatre in which he/she has a part. The therapist authors a story with some coherence about the conversation, and becomes the protagonist of his/her own story.

Viewed thusly, the therapist’s inner conversation can be described as a dialogue between the experiencing self and the professional self. The therapist creates a reflective inner space. In this space, the therapist reflects on his/her experiences and on his/her position in the conversation, as well as on what he/she will do next. Here the therapist's responsibility is of central importance, because this is where the therapeutic and ethical choices are made.

Recently, we studied the therapist’s inner conversation as a dialogue between the experiencing self and the professional self in a more systematic way, using a tape assisted recall procedure to obtain therapist reflections during role played sessions (Rober, Elliott, Buysse, Loots & De Corte, 2007a; Rober, Elliott, Buysse, Loots & De Corte, 2007b). We analyzed the data using a grounded theory method and we proposed a descriptive model of the therapist’s inner conversation with four positions: attending to the client’s process, processing the client’s story, focusing on the therapist’s own experience and managing the therapeutic process. The model highlights the importance of the dialogue with the client for the
therapeutic process, as the therapist’s first concern is with tuning into the client and with the
dialogical creation of a space to talk in which the client can tell his/her story (Rober, e.a.,
2007a). In addition, in the model the therapist’s self is portrayed as a dynamic multiplicity of
inner positions embodied as voices, having dialogical relationships in terms of questions and
answers, or agreement and disagreement (Rober, e.a., 2007b). Furthermore, the model shows
that, although the dialogical self is decentred and comprises a multiplicity of inner voices, it is
not fragmented or chaotic. Rather, it has some coherence and some organisation, in such a
way that it fits the therapist’s role as professional, and the social expectations that he/she is
helpful to the family in distress (Rober, e.a., 2007b). Some of these aspects of the therapist’s
inner conversation will be illustrated in the following case vignette.

Case vignette

The main aim of the following analysis is to illustrate in what way the inner conversation of
the therapist is a valuable conceptual tool enriching our thinking about the complexities of
family therapeutic relationships in practice. It illustrates how the self of the therapist can be
described as a polyphony of different inner voices, one evoking the other, in his attempts to
make sense of what happens in the session and to be helpful to the family. First, I will present
the transcript of the session¹, without the therapist’s inner conversation (see transcript 1).
Johnny is a 14-year-old boy referred by juvenile court because of extreme violent behavior.
We are some twenty minutes into the first session with Johnny and his mother.

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¹ The case vignette is a transcribed excerpt from a videotape of a therapeutic conversation that took place in a
community therapeutic center. Mother and Johnny (pseudonym) were informed about my research project on
the therapist’s inner conversation. They gave me their consent to use the tape of their session for the project, on
the condition that I would wipe the tape after I made the transcript.
Transcript 1

...  

Mother is crying silently. Johnny addresses the therapist, and smiles.  

“I hate her, and if she keeps messing with me I will kill her,” he says.  

Mother is crying harder now.  

The therapist hands her the box with Kleenex.  

She takes one tissue.  

The therapist asks her: “If your tears could talk, what would they tell us?”  

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.”  

...  

This transcript describes a particularly dramatic sequence in the session. The boy speaks threatening words; the mother cries harder. Then the therapist comforts her, and asks her to talk about her tears.  

I will now present the same vignette, but in addition to the transcript of the conversation between the mother, Johnny and the therapist, I will also consider the therapist’s inner conversation (see transcript 2). The inner conversation in this transcript was reconstructed using a tape-assisted recall procedure. Tape assisted research procedures are inspired by the work of Kagan (1975), and have been very productive in psychotherapy process research (e.g. Elliott, 1986; Rennie, 1994). The procedure used for this transcript followed two steps.
First, the session with the family was recorded on videotape. Secondly, 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.

**Transcript 2**

<table>
<thead>
<tr>
<th>Outer conversation</th>
<th>Therapist’s inner conversation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother is crying silently. Johnny addresses the therapist, and smiles: “I hate her, and if she keeps messing with me I will kill her.” (1)</td>
<td>(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 mother mentioned that she was afraid of her son. Is he really threatening to kill his mother?</td>
</tr>
<tr>
<td>Mother is crying harder now. (2)</td>
<td>(2) I feel sadness coming on and I want to comfort her.</td>
</tr>
<tr>
<td>The therapist hands her the box with Kleenex. She takes one tissue. (3)</td>
<td>(3) I think that it’s not up to me to comfort mother. I should invite her to talk instead.</td>
</tr>
<tr>
<td>The therapist asks her: “If your tears could talk,</td>
<td></td>
</tr>
</tbody>
</table>
what would they tell us?"
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.” (4)

(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 mother for comfort. My comfort.

In the therapist’s inner conversation, we 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 mother? Let us now look more closely at the therapist’s inner conversation. We can distinguish four reflections in this short transcript.

(1) The first reflection is evoked by Johnny threatening remark “I will kill her.” 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, suggesting that he is surprised and overcome by this rush of strong emotion. Several inner voices start to weigh the possibility of homicide as he tries to assess the danger. These reflections seem to bring back some balance in his inner conversation, as they seem to push back the inner voices expressing fear.

(2) The second reflection is invited by mother’s crying. In the face of the woman’s weeping, the therapist reports his own sadness, and this inner voice immediately mobilizes another voice replying that he wants to comfort mother. The therapist seems to take no time to reflect on this inclination, and seems to jump rather
impulsively to offering her the box of Kleenex, positioning himself as comforter, mother as victim and Johnny as perpetrator.

(3) The third reflection can be understood as a correction of the therapist’s previous actions, and as a more reflective reply to the impulsive voice that took precedence in the previous entry. The therapist describes a therapist’s role in general as inviting the client to talk, rather than as actively intervening in the family and its management of emotions.

(4) The final reflection of this transcript adds further reflections on his actions and his management of emotions. The therapist realizes that his impulsive reactions in the past minutes were inspired more by his own fear and insecurity, than by his empathy for the mother. Possibly this reflection could only be made after he was reassured that there was no real danger of homicide.

This is an analysis of this very brief transcript, using the concept of the therapist’s inner conversation. As a clinician such an analysis helps me to sense some of the complexity of what happened in the session, and understand the way in which fear and threats played an important role in how the family members interacted. Of course the transcript in fact begs to be analyzed in more detail. In the context of this article, however, our brief analysis suffices to demonstrate one of the ways in which the concept of the inner conversation of the therapist can contribute to a richer understanding of the complex mutuality of the family therapeutic session, and the vulnerable place of the therapist in that session. The analysis illustrates how the therapist is emotionally affected by what happens in the session, and how he tries to master his own emotions in the session, while searching for a position to be useful to the mother’s process.
In our analyses of transcripts of sessions—for research purposes, as well as for training and supervision—we deliberately use the concept of “positioning” (Davis & Harré, 1990; Harré & Van Langenhove, 1999) for the inner conversation, as well as for the conversation between the family members and the therapist, because this concept is a dynamic metaphor that offers the possibility to highlight the differentiation of inner as well as outer voices, localizing them in time and space, not as things or parts but instead as vantage points, implying that the world is always seen from a particular vantage point, and not from another (Hermans, 2004a, 2004b). The concept of “positioning” contributes to a better description of the dynamics of the dialogical self, where one voice comes into being in dialogue with another voice, inner or outer; as if it were invited by this other voice (Rober, e.a., 2007b). The concept also helps us to describe the therapist’s inner conversation in the context of a therapeutic session, enriching our thinking about the complexities of therapeutic relationships; especially in as far as family therapy is concerned. Indeed, in comparison to an individual session, in a family therapeutic session even more voices are involved, and one of the challenges of the family therapist is exactly how to position oneself—“outside therapy, while inside” (Larner, 1998, p.567)—in the complex stream of voices, inner and outer, during the session.

The next case story—a story about individual therapy as well as about family therapy—will illustrate how the concept of the therapist’s inner conversation is useful as it makes certain experienced, but unnoticed aspects of being a therapist in practice accessible for reflection and discussion. The story will also bring together some of the concepts that I touched upon in this article.
Case story of Liza

Liza, a woman of 25 years old, came in therapy because she had been abused as a child by her father. Already in the beginning of the first session I felt a vague uneasiness. I wondered what was wrong. At first I couldn't put my finger on it. Maybe it was nothing. After all, it was a vague feeling. On the other hand, maybe it was meaningful. Could it help me to understand something about the client, I wondered. I urged myself to take this uneasiness seriously. I decided to look more closely at what was happening in the session. I noted that Liza answered my questions, but that her answers were rather brief. Also, she looked very tense, I reflected. I noticed she made no eye contact. In fact, she seemed irritated and she made me feel as if she didn't trust me. I reflected that maybe she was angry with me. But I had never met her before, what could she be angry about? Maybe it was something I had said that had hurt her. Or, maybe she was just tense, as some people are at the beginning of a therapy.

These are different inner voices induced by what is happening. They were given room to emerge, evoking each other (e.g. “Maybe she is angry with me?” evokes “How could she be, I have never met her before?”). As a therapist, I tried to be open to these voices –not knowing and curious- wondering if they would help me to make some sense of what was happening in the session, and hoping that they would give me clues about how to go on with the conversation.

Then I asked Liza if she was feeling tense.

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2 Liza (pseudonym) gave me permission to use her story in this article. When I asked her permission to use it in a professional journal for therapists, she replied: “By all means. Maybe it can teach your colleagues to carefully listen to what their clients can not yet say.”
Afterwards I wondered why I asked this question. I had tried to listen to the different aspects of her storytelling: what she said, what she showed, and also how she made me feel. In my inner conversation, several ideas and voices, had emerged. And then I somehow came up with this question: “are you feeling tense?”

But why exactly did I pick this question? I don’t really know. There certainly was no deliberate strategy behind it. With the benefit of hindsight I think I must have experienced this question as sufficiently connected with some of my inner voices, while at the same time it was not too intrusive for this new and brittle therapeutic relationship. It must have been some kind of knowledge of the third kind –out of my intentional control, but making sense in the dialogical context- as I would learn later that it was well tuned into the process of the client. It is an example of what Schmid calls the personal resonance of the therapist in relationship with the client (Schmid & Mearns, 2006) and in parallel with Behr’s process of interactive resonance in person-centered play therapy (Behr, 2003). It is an illustration of how the therapist is often positioned in therapy: inside while outside, inviting change but never controlling it, and depending on his knowing in action to lead him in on the spot tacit decisions. Anyway, in retrospection I can say that it proved to be a good question, as it opened space for a story that explained a lot to me.

At first she was silent.

I asked her again: “Are you tense?”

Then she said that it was not easy for her to come to therapy.

"Can you help me understand that?" I asked.

Liza answered that she had been thinking about going into therapy for a long time, but she had always postponed it: “Even just now, while I was sitting in the waiting room, I contemplated walking out again," she added.
I again asked her if she could help me understand.

Then she told me the following story:

"My father has abused me the first time when I was four or five years old. He came to my room at night when everyone in the family was sleeping, and he raped me. Afterward he said to me that I should never talk about it, because it was our secret and if I would talk then he would go to jail. So I didn't talk about it but the following nights he came again and every time he raped me. One night I had wetted my bed. When father came and he noticed the bed was wet, he got angry with me, and he called me a filthy, dirty slut, but he didn't rape me. So I had found a way to protect myself against him. Since that night I wetted my bed every night.

Soon my mother noticed I was wetting my bed. So she talked to the G.P and he referred us to a therapist.

When my mother told me we would go to a therapist, I felt my hope rising. Maybe now there would come an end to the pain and the fear and the shame.

In the first session with this therapist, however, I noticed that the therapist was only concerned with finding a solution for my bedwetting. He didn't seem at all interested in the family relations or in the how and why of the bedwetting. I have to admit that in some way that was a relief, because I feared the confrontation with my father. At the same time I was very angry with the therapist, not only because he didn't notice that there was more to it than just bedwetting, but also because he was searching for a solution for the bedwetting, and he didn't seem to notice that he was going to take away the only protection I had against my father. So I sabotaged the solutions he proposed. I also swore I would never trust a therapist again."
In retrospect, I think that it must have been this resolution to never trust a therapist again that I had experienced as uneasiness. In response to vaguely experiencing this uneasiness—it would have been very easy to discard it as unimportant—, I tried to make sense of it in my inner conversation—listening to the different inner voices, contradictory as they were. This resulted somehow in the question “are you feeling tense?”, that created room for the telling of Liza’s story. I was relieved when she told me this story. It helped me to understand some of the things I experienced. Furthermore, the story also resolved part of the distrust Liza had towards me as a representative of the therapist profession.

**Conclusion**

Family therapy is a complex process, about which Larner (1998) writes: "This is where the therapist stands: outside therapy while inside, and with a sense of humility and astonishment when change occurs." (p. 567) It is a process characterized by uniqueness and unpredictability, which often leaves therapists with a lot of questions about what to say or do, and how to position him/herself. Authors in the family therapy field have suggested key concepts like neutrality and not-knowing as guiding principles to help therapists deal with these questions. These concepts, however, are usually not very helpful as they are too crude to connect with therapists lived experiences and fail to address the full complication of the relational processes of a family therapeutic encounter in practice in a satisfactory way (e.g. Flaskas & Perlesz, 1996; Flaskas, Mason & Perlesz, 2005).

In this context, the concept of the therapist’s inner conversation might offer potentially rich perspectives for the future. Rather than a guiding principle about what the therapist should do, or how he/she should position in the session, it is a tool that can be drawn on to think and talk
about the therapist’s positioning and experiencing in the session, and as such, it gives access to tacit aspects of the therapist’s self in practice. The concept might be especially useful in training and supervision. In training it can be used to attend young therapists to the rich resource the self is (Rober, 1999; Lowe, 2004). Furthermore, the concept helps to orient training at helping therapists to deal with the tensions that exist between the main I positions that are evoked in the therapist during the session (Rober, e.a., 2007b). In supervision, the concept of the therapist’s inner conversation can be a tool offering a richer understanding of therapeutic impasses (Rober, 1999; Flaskas, 2005). It suggests that a central question in supervision is, in which way the tension between the main I positions in the therapist’s inner conversation can be used to promote the dialogue with the clients and, ultimately, the therapeutic process of these clients.
Referenties:


