The therapist's experiencing in family therapy practice

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ABSTRACT

The question posed in this article is how the therapist should deal with strong emotions he/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 toward answering this question and propose that the therapist would be sensitive to his/her 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 his/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 can 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 can 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.

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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 & Horvath, 1999; Martin, Gaske & Davis, 2000; Orlinsky, Ronnestad & Millutzki, 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 & Ronnestad, 2005, p.179). This seems to be true in psychotherapy in general, as in family therapy in particular (Sprenkle & Blow, 2004; Blow, Sprenkle & Davis, 2007; Carr, 2005). The question I want to pose in this article, however, is how the therapist should deal with strong emotions he/she might experience in the session. Especially if it are emotions that at first sight do not seem to contribute to a positive working alliance. What should a therapist do when he/she experiences emotions like irritation, hopelessness, sadness and fear in the session? I will propose some ideas that address these questions. They deal with the complexity of the therapist's experiencing and his/her vulnerability in the session, in such a way that some of the therapist's difficult or ambivalent experiences in therapy can become useful to promote a collaborative therapeutic dialogue. These ideas can 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 of reflection (e.g. Elkaïm, 1997; Flaskas, 2005; Larner, 1996, 2004). Furthermore, they fits with a dialogical approach to family therapy (Seikkula & Olson, 2003; Rober, 2005b) in which the therapist's task can 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 can be specified as "how can the experiencing of the therapist help him/her to listen and create room for dialogue?"

THE COMPLEXITY OF BEING A THERAPIST

Pope & Tabachnick (1993) asked 600 randomly selected professional therapists in a survey study about the feelings they have experienced in their work. Over 80% 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% 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, because of the extreme complexity of the family therapeutic conversation and its saturation with immediate emotions. The 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 took 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 a therapist to find his/her 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 it is 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 to deal with difficult emotions like shame (Kaver & McNab, 2005), despair (Flaskas, McCarthy & Sheehan, 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 the therapist as they raise doubt in therapist's mind about his/her professionalism and his/her therapeutic skills. Furthermore, they can lead to alliance ruptures (Safran, Muran, Samtag & Stevens, 2002). Also they may push therapists in dialogical positions that lead to impasses that are not helpful or even destructive for the therapeutic process (Rober, 1999; Flaskas, 2005).

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 psychoanalystic theory and practice. First Freud thought of 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, 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 a lot of attention to the therapist's experiences in the session. Especially after the postmodernist and narrative turn hit the field at the end of the 80's, the emphasis was on the client's expertise (Anderson & Goolishian, 1992), and on harmonizing with the client (Smith, 2004). While this indisputably was 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 of colonizing the client and robbing him/her of his/her own voice (Rober & Seltzer, submitted).

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 started to explore the dialogical character of the family therapeutic meeting (e.g. Andersen, 1995; Seikkula & Olson, 2003; Rober, 2005b), partly based on their study of Bakhtin (1981, 1984; 1986) and Voloshinov (1973). Within the frame 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; Rober, 1999, 2002, 2005a; Lowe, 2004; Flaskas, 2005).   This concept refers to the private dialogue the therapist has with him/herself, while he/she is talking with the family. Rather than a guiding principle about what the therapist should do, or how he/she should position in the session, the therapist's inner conversation is a tool that can 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 of different therapeutic schools with a role played client[1] (Rober, Elliott, Buysse, Loots & De Corte, 2008; Rober, Elliott, Buysse, Loots & De Corte, 2008). We used a tape assisted recall procedure to gain access to the therapist's inner conversation (Kagan, 1975; Elliott, 1986), and we did a grounded theory analysis on the data (Strauss & Corbin, 1998; Charmaz, 2006). 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 a in depth discussion of this research of the therapist's inner conversation, here 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 with the client; 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, e.a., 1980).

Another conclusion that can 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

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[1] This research is described in detail in some of our earlier publications (Rober, Elliott, Buysse, Loots & De Corte, 2008; Rober, Elliott, Buysse, Loots & De Corte, 2008). Therefore we will suffice here with a brief summary of the research.

concerned to be in tune with the client's expectations, preferences and vulnerabilities (Rober, Elliott, Buysse, Loots & De Corte, 2008). 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 to him/her.

A third conclusion that 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 entail exactly. Our study suggests that there are three aspects of the therapist's active listening (Rober, Elliott, Buysse, Loots & De Corte, 2008):

 1. Processing the client's story: This refers to the therapist's processing the content of the client's story about 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/her

own experiencing. The therapist is listening to the story the client invites him/her 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 can be linked to some of the traditional writings on the psychotherapeutic encounter, like psychodynamically inspired publications on countertransference and projective identification (e.g. Skynner, 1987; Flaskas, 2002). It may be less obvious but these levels can also be linked to publications highlighting the importance of silence in the expression of suffering (e.g. Charmaz, 1999, 2002; Pearlman & Saakvitne, 1995; Scott & Lester, 1998; Compare, 2007). 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 in 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 & Saakvitne, 1995, p.23). That's why some authors from the trauma literature consider the therapist's experiencing as a tool for understanding (Pearlman & Saakvitne, 1995): What is evoked in the therapist's experiencing are the parts of the client's story that can not be expressed otherwise.

Also in the family therapy field there have been publications in which the therapist's experiencing in the therapy session is valued as a tool for understanding and dialogue (e.g. Whitaker & Keith, 1981; Andolfi, Angelo & De Nichilo, 1989; Real, 1990; Haber, 1990, 1994; Flaskas, 2002). 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 the therapist experiences in the session does not only come from his/her 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. Also 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 therapist's inner conversations while he/she is talking to the family (Hoffman, 2002). Elkaïm and Hoffman suggest that therapists know more that 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 the therapist to reflect on his/her

experiencing in the session. Now 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 remark that the case vignette of Johnny and his mother is offered in the form of a transcript in two columns. 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 conversation. The inner conversation in this transcript was reconstructed using a tape-assisted recall procedure (Kagan, 1975; Elliott, 1986). 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.

The case of Johnny and his mother

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.

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 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	The therapist hands her the box with Kleenex.		
OC 5	She takes one tissue.		
		TIC 3	I think that it's not up to me to comfort mother. I should invite her to talk instead.
OC 6	The 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 mother for comfort. My comfort.

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 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 can 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 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 (cfr 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/her 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 can notice the therapist jumping in rather impulsively to offer 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 mother the box with Kleenex models an important behavior for the teen, 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 can be experienced as blaming by Johnny: he is excluded from the positive interaction between mother and therapist, and implicitly labeled 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 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 mother's tears, it may rob somebody else from the occasion to comfort her.

The question can be posed what the therapist could have done instead of offering the Kleenex to the mother. Judging from the therapist's reflections in his inner conversation (TIC 3), he himself considered his impulsive comforting reaction 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 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 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 was caught up in a relational scenario after all (TIC 4): for his own comfort he had been seeking the reassurance from mother that there was no real threat. So it

seems that while on one level he was trying to comfort mother, on another level he was seeking comfort with 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 be argued that also here 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 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 session when 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 realised 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 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 therapist. What is the therapist feeling? What are the therapist's intentions? What are

the emotions he/she is struggling with? What are the dilemmas he/she is facing? What are the fantasies he/she is dealing with?   And so on.   The therapist's experiencing –in this context- is broader than just the therapist's feelings.   For instance, also some of the therapist's internal judgments of the therapist can 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 take 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/she inclined to play in the dialogical context of the session? As these relational scenarios in which the therapist is invited to play a role in can sometimes be destructive because they perpetuate unhealthy or pathologising interactions between the family members (Flaskas, 2005), it is also important for the therapist to ask him/herself if it would be helpful for the family if the therapist would play that part in the scenario. Would it open 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 in the dialogue as a therapeutic opportunity. Is it possible to introduce something of the therapist's experiencing in 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/her questions in such a way that the destructive scenario that lies waiting is avoided, and dialogical space for the not-yet-said is opened instead? Especially in cases of therapeutic impasse this may involve a lot of reflective work on the part of the therapist as he/she has to find constructive ways to

think about the family instead of the pejorative and rejecting thoughts that are occupying him/her in this gridlocked situation (Rober, 2002; Lowe, 2004; Flaskas, 2005). Through these reflections a renewed curiosity can develop in the therapist, leading to a fresh empathic connection with the family members and re-opening space for rich and surprising dialogues.

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

CASE: 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). Mother was depressed and disappointed after she divorced her husband 3 years before. 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.

[insert figure 1 here]

In the first session, 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 mother in any way in the house. Taking no responsibility, doing whatever caught their momentary fancy and asking their mother's

financial help whenever they needed something. And when mother said no, or tried to be stricter with them, they became aggressive and verbally abused her. Mother did not feel respected by them. One example: Frank used mother's car all the time. She had to ask his permission when she wanted to use her own car. Also, Frank often drove very fast and got a lot of speeding tickets. But, since it was 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 been fined with more than three speeding tickets in one month's time. The judge reproached her for reckless driving and took away her driving license for several weeks.

When I heard the stories about what happened between 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 mother, implicitly I began to gently push mother into being more assertive and strict towards her sons. After a while I invited her to speak firmly with 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 and spoke to the boys. The sons reacted 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 charms made 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 mother to try once more to be stronger. Indeed, now she sounded a bit 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 anymore. I saw that mother was hurt by Frank's words. She reclined in 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 fantasised that I would take the children to see a psychiatrist. They needed to have a diagnostic evaluation and probably medication, I fantasised. The session ended with the children saying that they would not come to the next session because they had more important things to do. And 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 mother –gently and implicit as it was- into being more assertive. I explored my own experiencing and realised that in fact I was outraged about how the children 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 with mother's resignation and passivity. This all resulted in my urging mother to act firmly. As this 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 realised that mother's resignation was probably the expression of the impotence she felt as a mother, after all her vain attempts to bring change in her family, and to make her sons respect her. Luckily, I also realised that my feeling of impotence could be an empathic bridge towards mother.

Mother came alone to the second session. She had tried to convince her sons to join her to come to the session, but they had refused to come. We talked and I apologized 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 she felt powerless in.

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 done to get them behave more responsibly and supporting.

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 what she had tried to get your 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 kept refusing to take any responsibility. She talked about the lack of respect of the children and about her protest that didn't amount to anything.

I asked her who else in her context might understand her powerlessness.

She said: "My sisters."

We talked about her sisters. In the previous years they had also tried to help her to be more assertive and stricter so that her sons would respect her. But to no avail.

At the end of the session I proposed that she would 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 came next session. I reminded them that we were united in powerlessness, and that at least *I* –maybe 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 mother added

that she was very grateful towards 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 your own kids. Mother shared her anger towards her ex-husband who had abandoned her, and she said, if it were not for her children, she regretted that she had ever met him. Interestingly, at a certain moment an unexpected new story emerged. One of mother's sisters talked about the sons' powerlessness. She told the story that Frank had confided her once in tears that he missed his father and how he had 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 convince him to return to the family. At first father had said he would think about it, but a few weeks later father phoned back to announce that he had married again, and that his young wife was expected a baby. "I will never be weak again," Frank had confided 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 as follows (see figure 2).

[insert figure 2 here]

Focusing on the therapist's experiencing, it is clear that the stories of the boys outraged the therapist and made him feel protective towards mother. Focused on the mother's passivity, he did not acknowledge mother's attempts to bring change, nor her powerlessness. 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 mother to do. Some might say that the therapist here took the place of the absent father; filling the gap father had left when he went to Asia. Maybe this is true, but anyway, the therapist pushed mother to act. Thereby he again put her through the depressing experience of being ignored, threatened and humiliated by her sons.

When the therapist after the first session took time to reflect on his experiencing in the session, he realised that he was involved in a destructive scenario with the family; labelling mother as the victim and protecting her, while blaming the sons. At the same time he realised 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 mother. Later, in the second session, he even saw the opportunity to use the feeling of powerlessness as a bridge between mother and her social support system (her sisters).

DISCUSSION

While outcome studies consistently highlight the importance of the therapeutic relationship, the family therapy field offers not a lot of 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 him/herself in the session with the family, such as neutrality (Selvini, Boscolo, Cecchin & Prata, 1980), curiosity (Cecchin, 1987), not-knowing (Anderson

& 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 & Keith, (1981), Elkaïm (1998) and Andolfi (Andolfi, Angelo & De Nicolo, 1989), who tried to meaningfully connect the experiencing of the therapist with the complex dynamics of the family therapeutic encounter, seem to be 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/her 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 his/her 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 the clinical examples we 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 the therapist often get him/her into trouble. Conversely, acknowledging experiences is sometimes tough as it also means to be 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 & Imes, 1978; Sightler, & Wilson, 2001), as it can give rise to the therapist's secret fear that he/she is not worthy of his/her position as a therapist: "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) Impulsively acting may be our way of protecting ourselves: keeping strangeness at bay and avoiding to really be aware of the confusing things we are feeling. That's why carefully reflecting on one's own experiencing and positioning in the session is important. It is however not always possible to find the time and space to really reflect on these things in 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 his/her positioning in the dialogue. These concepts can assist the therapist to find ways in which his/her experiencing can open space for new and enriching dialogues with the family members, between the family members, and between family members and their social context.

CONCLUSION

The approach introduced in this article can 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 in the course of a session, and especially when the family therapist feels stuck, it is important for the therapist to give attention to his/her own process and reflect on the way it might be intersecting with what is happening in the session. We proposed the three concepts that can 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 can be seen as representing three steps in a process of reflection:

Step 1. The therapist is sensitive to his/her 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, and

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 that 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 of reflection can be hazardous for the therapeutic process. The approach presented here can be considered a potential path for therapist's to prevent to get 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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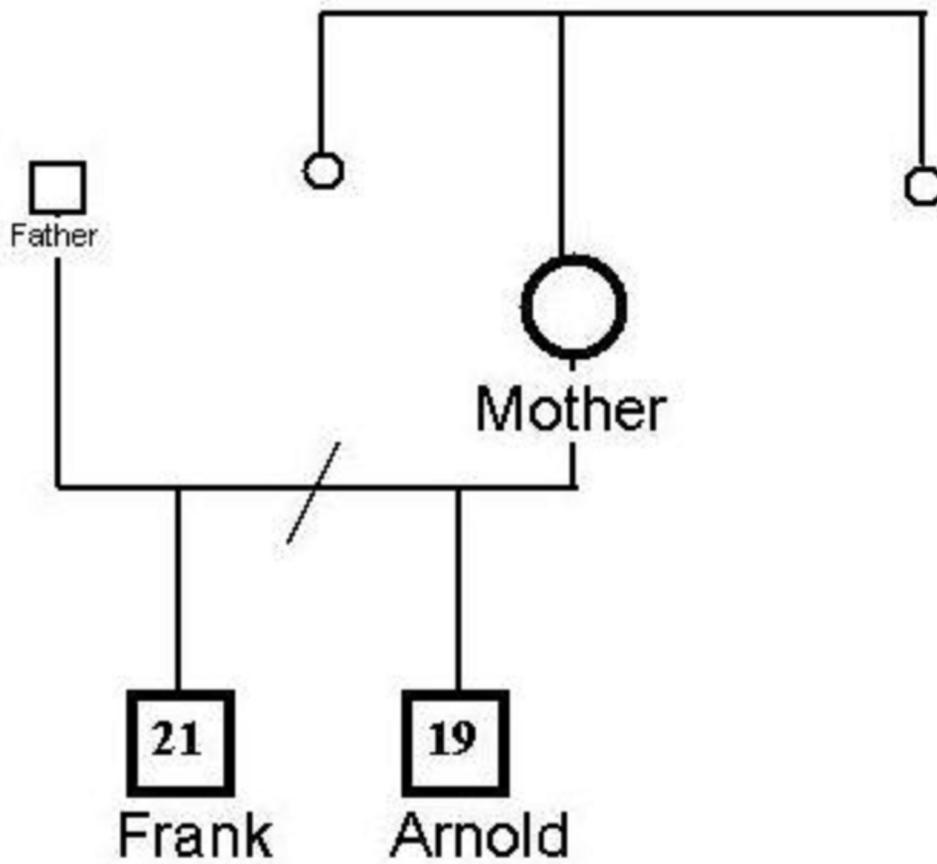
Figure 1: Genogram of the Janssens family

Figure 2:

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

the therapist's experiencing	outrage, feeling protective, powerlessness
invitation to act	*(first)* working hard, pushing for change, *(ultimately)* mounting frustration, impotence, blaming ("spoiled, …"), fantasising about calling a psychiatrist in for diagnosis and medication…
opportunity to dialogue	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.