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"The real voyage of discovery consists not in seeking new landscapes but in having new eyes" (Proust).

CHAPTER 1

GENERAL ORIENTATION

1.1 INTRODUCTION

The field of family therapy is vast and complex and the evolution of family therapy from first-order cybernetics to the postmodern theoretical environment has come about through acknowledgement that there are different, but equally valid ways to view the world. Epistemological change has been influenced by the fact that families are changing and diversity in many ways is evident in practice (Mills & Sprenkle, 1995:368). Epistemology refers to the study of knowledge, how we understand and make sense of reality and the way in which we construct meaning. It is a framework for describing and conceptualising what is being observed and experienced (Goldenberg & Goldenberg, 1996:423).

Historically, the family has played an important role in the life and development of people and society and, according to Gladding (2002:4), maintains many of its original functions, such as the socialisation of children, emotional support, and economic cooperation. Throughout history, family members have endeavoured to be a source of support and assistance to each other. However, tension exists within the family structure, with both environmental forces and internal relationship factors impacting on family functioning.

Family therapy has its roots in the 20th century, with many events shaping the evolution of this type of human intervention. The role of the family in the creation and maintenance of psychological difficulties began to receive attention in the 1950s and, according to Anderson (1999:1), family therapy developed through recognition of a

broader view of human behaviour within the context of the family. The result was a paradigm shift from an intrapersonal focus to one that paved the way to conceptualise human problems as interpersonal, and created new ways to understand human behaviour. Goldenberg and Goldenberg (1996:69) describe a number of clinical developments upon which family therapy was constructed: psychoanalysis; general systems theory; the role of the family in the etiology of schizophrenia; marital and child guidance; and, group therapy.

Gregory Bateson was one of the founders of the discipline of family therapy, incorporating biology and the social sciences into the cybernetic concepts and systems theory, thus formulating a "…creative transdisciplinary approach" (Pakman, 2004:413). Together with von Bertalanffy, their ideas came to be known as the field of cybernetics. Cybernetics is a term used to refer to the study of the way in which mechanical and biological systems use feedback to maintain stability (Carr, 2000:73). Family life was viewed as a pattern of interactions, mutually generated and based on continual processes of stability and change.

Many different family therapy approaches have evolved, some based on systemic and cybernetic concepts. These include theories that focus on behavioural patterns (e.g. strategic, cognitive-behavioural and structural approaches), and theories that focus on context (e.g. psychoanalytic, transgenerational and multisystemic) (Carr, 2000:70). Such theories are based on modernist premises which privilege the existence of value-free knowledge discovered through empirical investigation (Carr, 2000:119). Criticism of the systems approach centred on it being mechanical, questioning the neutrality of the systemic therapist, the 'expert' position and reliance on objective observation.

Dissatisfaction with systems/cybernetic theory has led to family therapists seeking a different philosophical paradigm for practice. Despite considerable criticism, postmodern theories that focus on belief systems, such as constructivism, social constructionism and narrative theory, have gained in ascendancy and it may appear that modernist theory is no longer relevant, being of mainly historic interest. Postmodernism

refers to a broad cultural transformation that occurred in response to the perceived failure of modernism to fulfil the promise of improvement through scientific progress (Carr, 2000:118).

Constructivism views the individual and the family as constructing meaning about the experiential world, with each person's view determined by his or her psychological and physiological make-up (Carr, 2000:141). Social constructionism argues that meanings are socially constructed through language and contribute to dominant beliefs, ideologies or discourses – the perceptions of the individual are determined through social consensus within the community. The latter view emphasises a wider socio-cultural context that may constrain meaning and the beliefs that people subscribe to (Dallos, 1997:31).

Nichols and Schwartz (2001:234) describe the narrative model of family therapy as "…the perfect expression of the postmodern revolution". The central assumptions of the narrative approach are that human experience is fundamentally ambiguous, and meaning lends itself to a multiplicity of interpretations. The truth of experience is created rather than discovered. Throughout human experience, people develop dominant and subjugated personal narratives that impact on their belief systems and thus, on their lives (Carr, 2000:148).

Auerswald (1987:317) explored epistemological shifts in the family therapy arena, stating that it is the only field of the behavioural sciences that has paid any attention to epistemological issues. Since the 1950s, five paradigms have emerged in the field of family therapy, namely, psychodynamic, family systems, general systems, cybernetic systems and ecosystemic; the last, according to Auerswald, being the only true epistemological shift. Family therapy would not exist without major epistemological shifts in thinking, allowing for the development of new and effective ways to work with families in distress (Auerswald, 1987:329).

Auerswald (1987:322) believes confusion has resulted from a failure to differentiate between the paradigms. A further source of confusion has been the evolution of science

as the Cartesian/Newtonian view of physical reality was questioned, changing the basis of the definition of reality. The researcher is of the opinion that paradigmatic confusion or a lack of knowledge about the shift in paradigms, could present an obstacle to the practice of family therapy at Family Life Centre.

The postmodern revolution gave rise to so-called second-order cybernetics, which attempted to correct the view of systems theory as mechanical and rigid, emphasising the role of the observer as part of what is being observed and the possibility of multiple constructions of reality. According to Dallos (1997:30), the involvement of the therapist "…perturbs the system", implying that the self of the therapist impacts on the family system, and that the role of distant objective expert is a fiction. Dallos (1997:30) sees the second-order perspective as not necessarily new, but as a more accurate reflection of the original core ideas of Bateson, quoting his view that a system is not simply a collection of behaviours but a system of interconnected meanings.

Bertrando (2000:83) views the conflict between modernism and postmodernism as an impoverishment of family therapy. He proposes an "…epigenetic…" view for the evolution of theories, believing the postmodern paradigm to be incomplete without a systemic perspective. Dallos and Urry (1999:161) suggest that both modernism and postmodernism have strengths that could be integrated to form a "…third order…" practice. Some synthesis and integration is called for, while at the same time remaining open to the meaning and value of the many theories. Amundson (1994:85) suggests therapeutic collaboration, by combining knowledge in ways that enable counsellors to choose from many possibilities, seeing this as best achieved in the "…spirit of pluralism" and a respect for knowledge at all levels.

Pilgrim (2000:6) reviews postmodernism and its relationship to family therapy, and posits an alternative to the "…naïve realism…" of modernist traditions and the postmodern paradigm which he views as cloaked in "…radical chic". Pilgrim sees the development of postmodernism as most useful alongside older, enduring traditions. Amundson

(1994:86) shares a similar view, arguing that many "…theoretical shelters…" exist and postmodernism is part of an evolving whole, rather than the "…last best thing".

In an essay that explores her own shift from the cybernetic view of family therapy to a social constructionist perspective, Hoffman (1990:11) believes that family therapists can only profit from the epistemological revolution that has occurred by moving therapy from biological and machine metaphors to those derived from the art of conversation and language. Mills and Sprenkle (1995:375) concur, stating that the transition from tradition to an appreciation of personal meaning evolving through language is more appropriate to the changing values of the present day.

An opinion expressed by Avis (1990:154), shared by the researcher, is that the practice of family therapy is best served by studying the principles of both modernism and postmodernism. The different theoretical backgrounds of counsellors at Family Life Centre add texture and depth to the practice of family therapy, but can also create confusion and a lack of confidence. The researcher is of the opinion that a sound, more scientific understanding of the different, yet not necessarily exclusive epistemologies may enhance the practice of family therapy.

The knowledge of experts in the field is of value, and the researcher intends to tap into the expertise of people working in the family therapy arena to gain insight into, and understanding of, the phenomenon of epistemological shifts in family therapy and the impact of these shifts on practice, as well as on the self of the family therapy practitioner. Ramsden (2005), a social worker as well as heading up Family Therapy at Family Life Centre, favours an eclectic orientation to family therapy, leaning towards a postmodern paradigm and believes that a sound grasp of relevant theory is essential to good practice. In addition, she believes awareness of one's personal paradigm to be an imperative to authentic practice.

According to Grobler (2005), a lecturer at the University of South Africa, family therapy practice necessitates an understanding of the different assumptions that are implicit in any

paradigm, be it modern or postmodern. However, theoretical knowledge is insufficient without knowing "…how we know what we know". In other words, we need to know the paradigm that informs our thinking and contributes to our capacity for reflexivity. This view highlights the importance of knowing the self in order to be a more authentic practitioner of family therapy.

Values play an important role in the social work profession, and underlie the mission and aims of social work (Van Dyk, 1997:99). Professional values reflect the way in which social workers practice, while personal values determine how we interact with clients. Value systems are unique to each individual and knowing our values forms a basis for knowing our selves. Du Toit, Grobler and Schenck (1998:222) pose a number of questions that can be used as themes to explore the congruence or genuineness of the self of the therapist. These include: awareness of our own experiences, feelings and behaviour; motivation for entering the helping professions; distinction between the professional and the personal selves; the development of the professional self; and, awareness of experiences that threaten the self. In the opinion of the researcher, the development of the professional (and personal) self is an ongoing journey that requires exploration and introspection with regard to both self and theory.

According to Van Dyk (1997:84), the meaning we attach to the field of study that interests us forms part of our unique professional development, and of the equipment we use when engaging in the helping process. Dallos (1997:xii) states that theories come and go in the field of family therapy, and stresses the need to reflect critically on these theories, as well as to develop a reflexivity that facilitates critical thinking and practice. Reflexivity refers to our level of self-awareness and empathy, linked to a cognitive understanding of our role and influence in professional human relationships (De Vos, 2002a:369; Clark, 2002:16).

Spinelli and Marshall (2001:1) posit that therapists rely on their theoretical approaches to give meaning and purpose to their work. These authors suggest that therapists interpret and even re-interpret their chosen approach from "…an embodied standpoint" and

attempt to explore how therapists live out the theories they espouse, and how theory challenges and informs their lives both personally and professionally. This raises questions on the nature of how a theory fits a particular therapist, what it allows, encourages or restricts, and curiosity about the initial reaction to the theory – was it one of familiarity or strangeness? Such questions provoke curiosity in the mind of the researcher, and have relevance for the training and practice of family therapy at Family Life Centre. The researcher is of the opinion that to work more scientifically, family therapists need to know what theory/theories they espouse (as well as having a working knowledge of the theories they do not feel comfortable in practising), and how these fit their sense of self and the capacity for authenticity. Being unaware of the interaction between the self and the theoretical intervention benefits neither the practitioner nor the client family as the recipient of therapy.

As practitioners we are representatives of our chosen theories, and while little, if any evidence currently exists to indicate the superiority of one theoretical model over another, many complex variables are present in the therapeutic encounter that impact on client outcomes. Baldwin and Satir (1987:153) emphasise that therapeutic techniques can never overshadow the fact that the self of the therapist is the "…funnel through which theories and techniques become manifest". These authors firmly believe that it is the therapeutic encounter that is potentially healing, quoting Yalom who argues that "…it is the relationship that heals". Satir (1987:23) too sees the use of self as integral to the therapeutic process, believing the self to be a tool for change that should be used consciously in intervention, while Shadley (1987: 130) defines the professional self as one that is constantly evolving and changing due to the conscious and unconscious interplay of many aspects. The term 'self' refers to an awareness of one's uniqueness and sense of personal identity (Reber & Reber, 2001:658).

The family therapist and therapist-in-training bring skills, ideas, experience and knowledge to the therapeutic arena which, according to Carlson and Erikson (2001:199), have seldom been honoured or validated in traditional training settings. In addition, the stories therapists enter into with their client's impact on their own lives, and the self is in

part shaped through the process of interpretation of the experience within the context of the client's story (White, 1990:81). Larner (1998:549) believes that therapy is situated in life - in the day-to-day experience of the therapeutic encounter we come into contact with real stories of human suffering that have an effect on the self of the therapist. The importance of knowing whom that self is, and how it affects and is affected by the therapeutic encounter is paramount.

In an autobiographical dissertation, Clarke (2002:1) explored her own changing assumptions as she grew throughout her training, and refers to an epistemological shift that may be experienced as "…liberating or shattering". For family therapists to be accountable to their clients and to themselves, an integration of personal and theoretical beliefs and values is required. There is reciprocity between theory and therapist – a therapist may choose a theory that fits with their worldview and values. However a theory can also shape and define viewpoints and values. In the process of gaining experience in the field of family therapy conducted at Family Life Centre, the researcher has become increasingly aware of the importance of knowing the self in the dynamic context of family therapy, where the interplay between the self of the therapist and the family in counselling is intricate and complex, requiring a high level of self-awareness and reflexivity. The researcher speculates that perhaps a deeper understanding of the theoretical evolution of family therapy, in conjunction with awareness of the personal paradigm of the family therapist and the impact of this on the self could enhance the development of confidence, competence and more authentic family therapy practice, as well as the capacity for reflexivity.

Family Life Centre, Johannesburg (established in 1949) is a non-profit organisation affiliated to FAMSA (Family and Marriage Society of South Africa). Initially operating to provide counselling for individuals and couples, the need for other services emerged, with Family Life Centre now providing a range of counselling services (individuals, couples and families), community services, group work services, divorce mediation, marriage preparation/enrichment, employee assistance programs, and training (both didactic and experiential).

At Family Life Centre, practitioners of family therapy come from a number of different training institutions, subscribing to differing theoretical bases. Although this provides richness and diversity, a sound, systematic body of theory relating to working with families is lacking as a component of the family therapy training program at the Centre. In addition, family therapy theory appears to be a fairly small component of most academic syllabi. The use of teams in family therapy occurs in many schools of therapeutic intervention, although they are used in different ways. The reflecting team model, first introduced by Tom Andersen, allows the client family direct access to the speculations, ideas and perspectives of the team members. The aim of this process is the generation of dialogue to facilitate the development of multiple perspectives and solutions for the client family (Biever & Gardner, 1995:47). The specific focal shift of the reflecting team approach to family therapy is from an 'either/or' frame to 'both/and'. The idea is conveyed that the problem is multifaceted and the family can discover the "…richness…" in the sharing of various points of view on the same issue (Andersen, 1987:427). Experiential training in family therapy, as part of a reflecting team, is the cornerstone of the training provided at Family Life Centre – beginning and experienced family therapists learn from one another in a culture that values many different 'voices'. A deeper awareness of the experience of reflecting team training and practice, as well as the addition of a more thorough and scientifically rigorous theoretical component may provide family therapy trainees and practitioners at Family Life Centre with a more holistic perspective.

The growing popularity of postmodernism is evident in the practice of family therapy at Family Life Centre. A seminar conducted by Michael White (2003) on narrative therapy was enthusiastically attended by most of the family therapy practitioners from the Centre. Other workshops, such as one held by Tom Anderson, M.D. (2001) on the use of language and the reflecting team approach were also well attended. However, there is a lack of a systematic body of theory provided to practitioners as a component of family therapy training at Family Life Centre. Counsellors are given a few articles to peruse, but for those desiring a more in-depth study, the responsibility lies with them to obtain additional theoretical material. The view of the researcher is that this emphasises the

passion and interest of those working in this fascinating field, but at the same time highlights the need for a more holistic, less piecemeal overview of the theoretical shifts and advances in family therapy theory and practice. It is the hope of the researcher that this thesis will contribute to the professional development of family therapy practitioners at the Centre.

The implications of a belief of the self of the therapist as central to the therapeutic process focuses attention on training that is not merely an emphasis on theory, skills and techniques, but also a sensitivity to a process that enhances the discovery of that self. The researcher concurs with the sentiments expressed by the authors mentioned above, and believes that a more holistic training experience can only benefit the practitioners of family therapy at Family Life Centre and the families they serve.

1.2 PROBLEM FORMULATION

According to Dallos and Draper (2000:179), the practice of family therapy has broken down certain professional taboos, especially secrecy, and replaced it with openness, collaboration, direct observation, live supervision and a more egalitarian approach to families – it is also a "…public demonstration of our own process of change". The process of family therapy can employ earlier theoretical ideas that have proven effective, with collaborative practice that is respectful, shares power, generates dialogue, and accesses strengths and competencies.

Soal and Kottler (1996:124) believe traditional theory and practice of family therapy to be constituted within "…hegemonic discourses…" that honour the desirability and naturalness of the 'typical' family, as well as serving to sustain such discourses. Work with families was previously guided by expert knowledge, standards and ideals against which the family were assessed, as well as serving a regulatory function. The postmodern movement recognises the hegemonic discourses that position people and families in particular ways, and that shape the problem-saturated narratives of the family.

The field of social work has undergone a paradigmatic shift, leaning towards postmodernism, and Ungar (2004:489) suggests an applied postmodern theory in social work practice that allows for the conviction that a co-constructed, negotiated meaning of reality is "…both justified and often just". The strength of the postmodern paradigm is the celebration of diversity with regard to multiple viewpoints and constructions of reality. Ungar goes on to state however, that the progressive social worker can still accept guiding principles relating to universal beliefs and behaviours (Ungar, 2004:490).

One of the positive legacies of postmodernism is dialogue about the various approaches as different ways of explaining problems, rather than arguing about which is correct. This view is relevant in the context of training at Family Life Centre, where differing approaches are respected and valued. However, the lack of provision of a systematic body of knowledge weakens the theoretical component of training, engendering confusion and diminishing confidence in practice. Family therapists need to know what school of thought they espouse, and significantly, what meaning it has for them and the way in which they practice. Of equal importance, trainees and experienced therapists need a solid background in the history of family therapy and the paradigmatic shifts that have led to the postmodern eclecticism espoused by Family Life Centre. This knowledge can only serve to strengthen the therapist's chosen theoretical framework and thus enhance the therapeutic relationship with the client family and his/her confidence in the reflecting team setting where different paradigmatic views are expressed.

The shift from theory to practice is often difficult. Despite the comprehensiveness of theory, little exists in the way of guidelines for practice. Some family therapy training contexts encourage participants to surrender their own systems of knowledge, skills and ideas, and copy their more experienced role models. The paradox of this being that it may be the unique, original aspects of the therapeutic process that are transforming for the family (White, 1990:85).

It may be difficult to accept that we all have a different world view, that what we observe differs, and that there is no 'truth'. The use of reflecting teams is suggested as a way of

overcoming such difficulties. This model, which is viewed as consistent with postmodern practice, focuses on multiple descriptions and explanations, the generation of ideas through dialogue, and respect for the family as expert on their own situation (Biever & Gardner, 1995:47). At Family Life Centre, family therapy is practiced in a reflecting team format. Reflecting teams are made up of an eclectic group, both in terms of composition and in theoretical orientation. Teams consist of staff members and sessional workers interested in working with families, final year social work students and Masters students of psychology from the Universities of South Africa, Witwatersrand and Johannesburg.

A study by Hanford (2004:99) explored the experiences of therapists-in-training in a reflecting team setting, focusing on self-reflection and willingness to risk 'difference'. Her conclusion is that participation in a reflecting team enhanced self-reflection in terms of awareness of self and of the process of family therapy.

Baldwin and Satir (1987:155) believe the development of the self of the therapist to be a continuous and ongoing process. However, learning about the self is an elusive, delicate and sensitive issue. Any therapeutic encounter, whether the client is an individual or a family, impacts not only on the client but also on the therapist. Denying or ignoring the development of internal processes that allow the therapist to become aware of destructive aspects in therapy may result in unethical practice. An unaware self can be dangerous to the therapeutic process. In addition, according to the abovementioned authors, the modelling of the integration of positive growth processes which are central to the therapeutic encounter becomes thwarted. An aware, alive and vibrant self is fundamental to both the therapeutic process and the well-being of the therapist, and Baldwin and Satir (1987:155) argue that such direct person-to-person contact lessens the danger of burnout and renews energy.

Duhl (1987:74) too expresses the view that any therapist must necessarily become aware of the systems within the self, and not only between persons. Implications for training are raising awareness of one's way of thinking and believing, (i.e. one's epistemology),

curiosity about one's own reactions and intentions in varying contexts, and developing one's capacity for creativity. Sussman (1995:23) poses the question of how therapists can effectively facilitate their maturational process, and states that a mature sense of disillusionment, necessary for full professional development, comes within the context of accumulated practice.

In support of the above, the researcher intends to explore the subjective perceptions, meanings and experiences of counsellors involved in the practice of family therapy with regard to the epistemological shifts in the theoretical field, theoretical 'fit', and the development of the professional and personal self of the therapist. The research problem can be formulated as follows:

Epistemological shifts in the field of family therapy have implications for both family therapy practitioners and the practice of family therapy. The lack of provision of a systematic, in-depth body of theoretical knowledge hampers scientific training and hence, the development of a theoretical approach that is authentic to the self of the family therapy practitioner. This necessitates the acquisition of knowledge and information that will enhance intervention in working with families, and promote the exploration and development of a reflexive self, thus improving the confidence, competence and authenticity of the family therapist in practice.

1.3 PURPOSE, GOAL AND OBJECTIVES OF THE RESEARCH STUDY

The purpose, goal and objectives of the study are:

1.3.1 Purpose

Exploratory research aims at gaining information about a topic and insight into the implications thereof, where little is currently known, the purpose being to formulate a problem (Bless & Higson-Smith, 1995:43). Fouche (2002:109) states that exploratory research is typically qualitative in nature.

The purpose of this research study is exploratory, intending to explore the implications of epistemological shifts in the arena of family therapy and the practice of family therapy within the South African context. An exploration of the acquisition and the embodiment of theory, experiential training, as well as the development of an authentic, reflexive self that may enhance intervention will also be undertaken.

1.3.2 Goal

McLeod (1997:83) sees the goal of research from a social constructionist philosophy as accessing a "…comprehension…" of alternative possibilities, rather than to produce knowledge that is universally valid.

The goal of the research study is to explore the perceptions, opinions and meanings that practitioners of family therapy give to the theories they espouse, and to gain insight into whether or not, and how, the epistemological shifts that have occurred in the field of family therapy have impacted on professional practice and intervention. In addition, the goal aims to explore how the self of the family therapist develops in relation to exposure to such shifts, in an attempt to achieve a personal synthesis that enhances theoretical knowledge and scientific intervention. Through exposure to experiential training and theoretical knowledge, the aim is to enhance awareness of the development of a theoretical approach that is authentic to the self of the therapist, and promotes therapist self-awareness, reflexivity, and confidence and competence in family therapy practice.

It is important to note that despite a belief in the value of a comprehensive theoretical foundation to the practice of family therapy, it is not the intention of the researcher to provide a 'recipe' for family therapy intervention. Rather, it is the search for a deeper theoretical understanding and meaning that is authentic to the self of the therapist, and to highlight awareness of the significance of one's idiosyncratic and unique impact on the therapeutic encounter, thus requiring the capacity for reflexivity.

1.3.3 Objectives

The objectives of the study are:-

1.3.3.1 Literature study

Through the literature study the following will be explored:

- The origins and history of family therapy, as well as an overview of the approaches to family therapy.
- A comprehensive theoretical orientation that will attempt to consolidate and deepen critical understanding of the different approaches to family therapy.
- Epistemological shifts in the field of family therapy.
- The impact of exposure to such shifts on the development of an authentic professional self, the integration of personal and theoretical beliefs, and the capacity for enhanced reflexivity.
- The reflecting team approach to family therapy as a method of sensitising the therapist to the multiplicity of perspectives and personal paradigms that exist in family therapy practice.

1.3.3.2 Empirical study

The empirical study aims to explore the following:

- The perceptions, opinions and meanings given by family therapy practitioners to their espoused theories and the impact of epistemological shifts on the professional self.
- An exploration of how the family therapist may evolve in the context of acquired theoretical knowledge, experiential training in a reflecting team, and critical reflexivity towards the development of a more authentic self and thus more competent and confident family therapy practice.
- Conclusions that will emanate from the findings to provide a systematic, scientific body of theoretical knowledge and enhance awareness of the need for a personal paradigm that is authentic to the professional self of the family therapy practitioner.

- Recommendations that will be of value to the training of family therapists and the practice of family therapy at Family Life Centre.

1.4 HYPOTHESIS/RESEARCH QUESTION/STATEMENT

According to De Vos (1998:116) and Collins (1993:33), a research question or statement is more relevant when a researcher is working from a qualitative paradigm. This approach aims to understand the meanings and perceptions people attach to their experiences – it is interpretive, holistic and ideographic (Fouche & Delport, 2002:79).

In a qualitative study the initial question or statement starts out broadly, becoming more focused during the research process. This allows flexibility and freedom to explore a phenomenon in depth. In this study, the researcher intends to explore the opinions, perceptions and meaning family therapists give to the theories they espouse, gain insight into whether or not, and how, theoretical shifts have impacted on professional practice, and explore the importance of knowing one's personal paradigm and the implication this has on professional practice and on the development of a self that is reflexive and authentic. The research questions in this study are:-

- **How do epistemological shifts in the field of family therapy influence the opinions, perceptions and meanings given to the espoused theories of family therapy practitioners?**
- **What are the implications of exposure to the epistemological shifts in family theory and enhanced theoretical knowledge on the development of reflexivity and the journey towards the discovery of a more authentic self?**
- **Does a deeper understanding and awareness of epistemological shifts in the field of family therapy facilitate the development of a reflexive, authentic self and thus enhance professional, scientific intervention?**
- **Does involvement in experiential training in family therapy facilitate the development of a theoretical approach that is authentic to the self of the family therapy practitioner?**

- **What are the implications of the development of reflexivity and the discovery of a more authentic self with regard to confidence and competence in the practice of family therapy?**

1.5 RESEARCH APPROACH

A number of authors discuss the various approaches to research. (Compare Fouche & Delport, 2002:79; Rubin & Babbie, 1993:330.) From a qualitative perspective, there is reliance on inductive reasoning, interpretation and producing descriptive data in written format. The aim of the qualitative paradigm is to elicit the meanings, perceptions and experiences of the respondents through in-depth exploration using small, purposively selected samples. The focus is on understanding rather than explaining, and on the subjective exploration of reality. Fouche (2002:106) suggests that the reason for undertaking a qualitative study is to explore a topic that requires a detailed narrative.

In this study, the researcher intends to use a qualitative approach to gain insight into the experiences, perceptions, feelings and opinions of a sample of family therapists/family therapists-in-training with regard to the phenomenon of epistemological shifts in the field of family therapy. In addition, the researcher will attempt to explore the 'fit' between theory and self, as well as a proposed link with the development of a reflexive, authentic self.

1.6 TYPE OF RESEARCH

According to Fouche and De Vos (1998:69), the researcher must make a decision regarding the purpose of the study. Is the intention to add to the knowledge base of the social work profession, or to address the application of research in practice?

Applied research aims at intervention by shedding light on, or providing solutions to, problems relevant to the practice of social work. Rothman and Thomas (1994:3-4) pioneered intervention research and identified three main types. These are:-

- Knowledge development (KD) – i.e. empirical research to extend knowledge of human behaviour.
- Knowledge utilisation (KU) – i.e. findings linked to and utilised in practice.
- Design and development (D & D) – i.e. research directed towards developing innovative interventions.

This study can be seen as applied research, more specifically knowledge utilisation (KU) as defined above. The aim is to extend knowledge of human behaviour relating to intervention in the field of family therapy. This will provide knowledge that can be used in practice to enhance awareness of the epistemological shifts that have occurred in the family therapy arena, provide a systematic body of theory for reference and training purposes, and elevate consciousness of the link between epistemology and the development of the personal and professional self of the therapist (Rothman & Thomas, 1994:18).

1.7 RESEARCH DESIGN AND METHODOLOGY

A research design is defined by Fouche and De Vos (2002:137) as a blueprint or plan on how to conduct research – the term design is generally used when working from a quantitative paradigm. Fouche (2002:270) cites Creswell who defines qualitative design as the entire process of research, encompassing conceptualisation of the problem to the written product. In qualitative research the design is flexible and unique, evolving as it progresses with few, if any, replicable steps. In a study aimed at exploration of unknown phenomena, Mouton and Marais (1990:43) see the purpose of a qualitative study as the defining of central concepts and determining of priorities for future research.

In this study the researcher intends to use a qualitative research design. A phenomenological strategy focusing on the subjective, idiosyncratic experience of people and the meanings they confer to phenomena will be used. For the purposes of this study, phenomenology is used in the sense of it being an approach that questions the meaning given to phenomena and how these meanings are experienced by the subject and the

intentions behind a subject's process of determining meaning, rather than seeing phenomena, meanings and reality as a given, non-negotiable entity (Audi, 1999:665). The phenomenological interview may produce data on a "…narrative version of … lived experience…" with the content seen as the 'real' meaning of a subjective experience (Henning, van Rensburg & Smit, 2004:53). This will entail the collection of data from a sample of family therapists working at Family Life Centre. The use of the interview method of qualitative data generation involves listening to 'stories' as part of a meaning-making process. Greeff (2002:292) cites Bergum who refers to a "…conversation…" in preference to an interview – this implies discussion and an attempt to understand the meanings participants give to their experiences. From a constructivist perspective, truth and knowledge cannot be discovered by the researcher, but are co-constructed with respondents to reflect their experiential reality. The researcher supports this view, aiming to understand the topic as respondents construct it, rather than seeking one 'truth'.

Greeff (2002:302) describes the semi-structured interview wherein the researcher attempts to gain an understanding of the beliefs, perceptions and opinions of respondents concerning the phenomena in question. Henning *et al.* (2004:65) believe the issue is not whether an interview is open-ended or meticulously structured, because even the decision **not** to structure is already a way to structure the event. An interview guide with set, predetermined questions may be open to "…discursive interpretation…". Discursive interpretation looks for meaning beyond the superficial and the obvious. It looks at the meaning a phenomenon holds for the respondent, on a content level as well as on an emotional level.

An interview schedule with a set of predetermined questions will be used as a guide to generate data on themes relating to "…the narrative terrain" (Holstein & Gubruin in Greeff, 2002:302). This will allow the researcher to focus on pertinent issues that will attempt to cover the topic thoroughly, with questions designed to help clarify and deepen the discussion. Greeff (2002:303) stresses that the questions must be logical, unbiased and address sensitive issues later on in the interview – however some deviation from the questions may be necessary to fully explore the phenomena in question.

Provisional themes intended for exploration include:

- Exploration of epistemological shifts in family therapy.
- Theoretical and experiential training of the respondent.
- Exploration of the 'fit' between respondent and espoused theory.
- Experience of participation in a reflecting team.
- Awareness of self in a therapeutic encounter.
- Awareness of the assumptions of one's personal paradigm.
- Awareness of one's capacity for reflexivity.

1.7.1 Data Analysis

Schurink (1998:241) states that qualitative research is an emic perspective of inquiry, whereby meaning is derived from the perceptions of respondents. Concepts are in the form of themes. Data analysis from a qualitative paradigm aims at descriptive data that explores the meanings of phenomena and is a process of bringing some structure to the accumulated data. Qualitative data analysis is an ambiguous, time-consuming, non-linear and creative process. Analysis involves an attempt to discover themes, recurring patterns and relationships among the categories of data (De Vos, 2002b:339-340).

According to De Vos (2002b:340), the methods of analysis in qualitative research have progressed in terms of formulation. Creswell (in De Vos, 2002b:340) refers to an analysis spiral, whereby the researcher moves in analytic circles starting with data (text or image), and ending with a narrative or description of the findings. For convenience, De Vos (2002b:340) presents the analysis spiral in a linear form, remembering however, that the phases move in circles. Five phases or steps are relevant: data collection and recording; managing data; reading and memos; describing, classifying and interpreting; and, representing and visualising.

1.7.1.1 Data collection and recording

The researcher is required to plan both for recording data, as well as for the retrieval of data for analysis. The researcher intends to collect data in the form of recorded interviews which will be transcribed. Data may also be collected in written or diagrammatic format, should respondents wish to augment their descriptions in such a way. Qualitative data analysis involves integration of data collection and data analysis phases. This may necessitate revisions to the data collection process as new data emerges, requiring a new analysis that may generate alternative hypotheses that form the basis for a shared construction of reality (De Vos, 2002b:341). Copies of audiotapes will be kept to facilitate transcription and the classification of themes, sub-themes, recurring phrases or words. Audiotapes will also provide the opportunity to revise the data collection process should this prove necessary.

De Vos (2002b:342) discusses the development of a working hypothesis during data collection. This entails a review of collected data, resulting in a variety of interpretations and culminating in a hypothesis that reflects a shared construction of the topic under study. The researcher may attempt to formulate a working hypothesis based on the insights derived from the data collection in integration with data analysis.

1.7.1.2 Managing data

Managing data is the organisation of data into files relating to text units, i.e. words, sentences, stories. The researcher intends to transcribe the taped interviews, which together with preliminary analysis, increases the efficiency of the data analysis (Marshall & Rossman in De Vos, 2002b:343). Transcription together with the literature review and initial thoughts on analysis can be a useful aspect of data analysis. The researcher will organise data in such a way as to ensure it is retrievable, making the transcriptions together with additional observational notes, theoretical notes and so on. Colour coding and/or numerical coding may be used to facilitate data management.

1.7.1.3 Reading and writing memos

Creswell (in De Vos, 2002b:343) suggests a thorough review of the entire set of transcripts in order to acquire a sense of the interviews as a whole, before deconstructing them into parts. During this reading process the researcher intends to make notes or memos to facilitate the organisation and retrieval of data. Writing memos in the margins of transcripts will enable the researcher to identify key concepts, ideas, themes, etc. that require reflection.

1.7.1.4 Describing, classifying and interpreting

The difficult and complex task of categorising data is, according to De Vos (2002b:344), the "…heart of qualitative data analysis". The analytic process requires attention to the data that is insightful and sensitive to the subtleties and nuances of the topic under review. The researcher will attempt to identify themes, sub-themes, patterns of belief, ideas and aspects that connect the respondents and that can be integrated to form categories of meaning. De Vos (2002b:344) emphasises that categories be internally consistent yet distinct from one another, not in the manner of quantitative exhaustiveness and mutual exclusivity, but in the identification of categories of meaning held by the respondents. Categories are the product of breaking down the data into manageable parts. Interpretation of the data may be based on intuition, hunches and impressions, or on social scientific constructs – this then involves challenging the apparent patterns for alternative explanations as to why the proposed one is the most plausible.

1.7.1.5 Representing and visualising

The final representation of the data is the creation of a form of presentation appropriate to the type of data collected and analysed. The researcher will present the data in text, since narratives will form the basis of the data generated. If appropriate, an alternative such as the metaphor may be used to represent the data. Any additional contributions by

respondents, such as their own writings or diagrams, may be included in the original format in which they were obtained.

Qualitative data analysis is a complex, creative process requiring sensitivity, insight and intuition as the researcher seeks to identify and describe alternative explanations and multiple perspectives.

1.8 PILOT STUDY

The function of the pilot study is to increase the precision of the study through exact formulation of the research problem and tentative planning on the nature and range of the investigation (Strydom, 2002a:211; Strydom, 1998:178). The pilot study involves a trial on a small scale to determine whether the methodology, sample, instrument and analysis are appropriate and adequate to the topic under investigation. The literature study is an aspect of the pilot study, the purpose being to orientate the researcher with regard to the existing knowledge on the proposed topic. Some of the bibliographic sources (e.g. Andersen, 1987; Auerswald, 1987 & 1985; Baldwin & Satir, 1987; Cecchin, 1987; Gilbert, Hughes & Dryden, 1989; Goldberg, 1986) may seem outdated. However in the opinion of the researcher, these sources are invaluable to the study, providing knowledge that is essential to an in-depth understanding of the relevant concepts. Other aspects of the pilot study include:-

1.8.1 Pre-test of Questionnaire/Measuring Instrument

A pilot study allows for a pre-test of the questionnaire or interview schedule in order to test its efficacy in terms of question formulation, interpretation, confusing questions and so on. Modifications can then be made if necessary (Strydom, 2002a:215; Strydom, 1998: 183).

A pre-test of the interview schedule will be conducted with one respondent (due to the small population), who will then be excluded from the main study, in order to explore the

relevance of the themes to be covered. In addition, colleagues may be consulted with regard to the construction of the interview schedule. Any modifications deemed necessary will then be made before the measuring instrument is used on the larger sample.

1.8.2 Feasibility of the Study

The feasibility of the research project is an important aspect of problem formulation and requires careful consideration (Rubin & Babbie, 1997:122).

The scope of this study is feasible as the organisation in question, Family Life Centre, has two teams of family therapists, averaging 4-5 members per team. The teams work on different evenings of the week, between 4.30pm and 6.30pm, and see one family per evening. In addition, some of the experienced family therapists will see a family without the use of the reflecting team format, should the waiting list become backlogged.

Family Life Centre requires the minimum duration of involvement in family therapy to be one year, thus allowing time for the researcher to collect data on an ongoing basis. The researcher will be able to conduct interviews with the members involved in family therapy who give their consent to be part of the study. Informal discussion with colleagues at the Centre indicates interest in the proposed research topic and a keenness to participate in the study.

The researcher is employed as a staff member at Family Life Centre, having been involved with the organisation from 1999 to the present, initially as a sessional worker and later as a staff member and part of the management team. In addition, the researcher is a facilitator of one of the family therapy teams. Any costs incurred will be at the expense of the researcher. Permission for the research study will be obtained from The Director: Family Life Centre. The requirements of the University of Pretoria are a research proposal which has to be approved by the Department of Social Work Research Committee. Once approved, this research proposal, together with a letter of informed

consent and an ethical questionnaire are submitted to the Ethics Committee, Faculty of Humanities: University of Pretoria, for the final approval before commencement of the empirical study.

1.9 RESEARCH POPULATION, SAMPLE AND SAMPLING METHOD

The research population, sample, sampling method and ethical aspects will be explored in the following sections.

1.9.1 Research Population

Strydom and Venter (2002:198) and De Vos and Fouche (1998:99) define the universe as all the potential subjects who possess the attributes relevant to the study, i.e. all family therapy practitioners. The population however, is the term referring to the individuals who possess the characteristics being studied and to whom the findings will be generalised.

The population of the study consists of all the practitioners working as family therapists/family therapists-in-training in family therapy teams at Family Life Centre: 1 Cardigan Avenue, Parkwood, Johannesburg, during the period January 2006 - July 2006. This group (as at January 2006, N = 9) comprises staff members, sessional workers (qualified social workers and psychologists with varying degrees of experience) and interns (psychology and social work students), from different geographical areas, racial, religious and cultural groups. At the time of writing, all of the population involved in family therapy teams are females, ranging in age from 26 years to 58 years. The population are all from the urban sector. Three practitioners are psychology interns, two from the University of the Witwatersrand, one from the University of Johannesburg, while another practitioner is an MA social work student from the University of Port Elizabeth. One psychologist has a D.Psych. degree from the University of Johannesburg. The remainder of the population are social workers, two of whom have a MA social work

degree, while the others have a BA (Hons) social work degree – these degrees have been obtained from the Universities of South Africa, Witwatersrand, and Pretoria.

*The researcher would like to note that this population may change during the data collection phase. Occasionally existing team members leave, new team members join, or former team members rejoin after a break, and some students/interns from the previous year continue to work in family therapy teams after completion of their studies in order to gain more experience.

1.9.2 Delimitation of the Sample

A sample is defined as a portion of the population that is representative of that population or universe (Strydom & Venter, 2002:198). According to Rubin and Babbie (1993:367), the aim of qualitative research is to select respondents who will best answer the research question, thus making controlled sampling techniques inappropriate.

The size of the sample is an important factor to be considered. Strydom and Venter (2002:200) suggest that the sample be sufficient to reflect a range of views so that outsiders may relate to the findings. If the total population is small, as is the case in this study, it may be necessary to utilise the entire population in an attempt to collect data that reflects the range of themes to be explored. The data collected in qualitative research is in-depth, requiring time to obtain during interviews and/or observation. The researcher intends to request the participation of the entire population of family therapists at Family Life Centre for the qualitative research study – however, this will naturally depend on their consent and willingness to be part of the study. Thus the population in this study and the sample are the same (N = 9).

Saturation point is reached when no new data is elicited during data collection, in other words when the same themes are emerging and no new information is forthcoming. However, according to Schurink (1998:304), this point may not be reached, as external factors (e.g. time, funds) may intervene. In this study, saturation point may not be

reached as the population/sample is small, and there will be no opportunity to increase the size of the sample as the number of family therapists at Family Life Centre is finite.

1.9.3 Sampling Method

Various authors discuss the different sampling methods. (Compare Strydom & Venter, 2002:203-206; Babbie & Mouton 2001:202-203; Strydom & De Vos, 1998:195-200.) In this research study, as mentioned above, the population and the sample size are the same, thus sampling methods are not applicable. However, the knowledge and expertise of the Head of Department: Family Therapy will be used to consider whether any team members should be excluded on the basis of vulnerability.

The population/sample will be purposively selected from the three family therapy teams operating on different evenings at Family Life Centre. Family therapy practitioners are currently employed as either staff members, sessional workers or as interns undergoing training at the Centre. The intention is to select all members of each team who give their informed consent to be part of the study. These team members have differing levels of experience (i.e. little experience, moderate experience, extensive experience). The following criteria are required:

- are currently involved in working in a family therapy team
- have a minimum of 6 months experience in a family therapy team
- levels of experience: little experience – 6 to 12 months; moderate experience – 12 months to 4 years; extensive experience – more than four years experience
- are committed to working in a team for a minimum of one year.

Since the population/sample size is small, other criteria such as age, gender, profession (i.e. social work or psychology) will not be considered as exclusionary or inclusionary factors in the research study.

1.9.4 Ethical Aspects

Ethics refer to a set of moral principles or more simply, what is considered right and wrong. Ethical issues are complex and data should never be obtained at the expense of human beings (Strydom, 2002b:62). Rules and expectations about ethical conduct towards respondents in the research study necessitate consideration. Such ethical issues to be considered and explored with respondents include: (Strydom, 2002b:64-73; Babbie & Mouton, 2001:546).

1.9.4.1 Harm to respondents

Social scientific research must ensure that respondents are not harmed, either physically or emotionally during the research process. This requires that respondents be fully informed of the potential impact of the study prior to obtaining their consent, and if necessary given the opportunity to withdraw. It is also necessary to try to identify respondents who may be vulnerable and possibly exclude them from the study (Strydom, 2002b:65).

In this study, the respondents will participate in a semi-structured interview that aims to explore their views, experiences and perceptions of the epistemological shifts in the field of family therapy and how these shifts may impact on the authentic self of the family therapy practitioner. Every effort will be made to ensure that no harm is done to respondents – this entails the value of, and belief in the utmost respect for the individuality of the respondent and the uniqueness of her experiential world.

1.9.4.2 Informed consent/voluntary participation

Strydom (2002b:65) states that respondents must be psychologically and legally competent to give their consent to be part of the study. Consent must be voluntary and respondents are at liberty to withdraw at any stage in the process. In addition,

respondents must be made cognisant of the goals, procedures, dangers, advantages and disadvantages of the study.

In this study the researcher will ensure that respondents feel under no obligation to participate by virtue of their being members of the family therapy teams at Family Life Centre. Respondents will be fully informed of all aspects of the study and their participation will be voluntary with no implied privilege or punishment for their consent to participate or not, as the case may be. Participation in family therapy teams, internship, and/or employment will not be contingent upon participation in the research study.

In addition, a letter of informed consent will be compiled and each respondent will be made fully aware of the contents before a request is made for their consent to participate. Respondents will be requested to sign the informed consent letter to indicate their understanding and agreement to participate in the study.

1.9.4.3 Anonymity/privacy/confidentiality

It is necessary to safeguard the identity of respondents and ensure their anonymity and privacy (Strydom, 2002b:67; Babbie & Mouton, 2001:546). This demands that no deceptive measures be used that could in any way identify their responses or their person. If tape recordings are made of the interviews, respondents will be made fully aware of this and their consent obtained before any recording is conducted.

The researcher will make every effort to ensure that respondents' identities are not made known, and ensure that their responses are not personally identifiable in any way. Tape recordings or notes from interviews will not be marked or made identifiable and all information obtained from the study will be treated with the utmost confidentiality. Data obtained from the interviews will not be kept on the Family Life Centre premises or shared with the colleagues and supervisors of any participants in the study.

1.9.4.4 Deception of subjects

All known aspects of the study, i.e. goals, experiences, and so on are to be accurately communicated to the respondents. Strydom (2002b:66) describes three reasons sometimes used to justify deception of subjects – these include: disguising the goal of the study; concealing the real function of the respondent's actions; and hiding the experiences respondents will endure. Ethically however, deception remains unacceptable for any reason. Respondents will be informed of the true purpose of the study, i.e. the researcher is undertaking a D. Phil for the purpose of enhancing the theoretical component of training at Family Life Centre, as well as exploring the link with the development of the professional self. No concealment of the purpose of the study or deception of the respondents is necessary in any way, and respondents are at liberty to refuse to participate if they choose.

1.9.4.5 Actions and competence of the researcher

It is essential that the researcher be competent to conduct the proposed study. This necessitates accurate reporting on data analysis, results and conclusions of the study. In addition, no value judgements are to be made concerning the personal views and experiences of respondents (Strydom, 2002b:69).

The researcher will be monitored and guided by her promoter, Dr G. Spies (Department of Social Work and Criminology, University of Pretoria) with regard to conducting a competent and ethical research process. At the same time, the personal integrity, values and ethics of the researcher will be consciously explored. All ethical aspects will be adhered to at all times. Should any inadvertent breach of ethics occur, this will be rectified immediately.

1.9.4.6 Cooperation with contributors

Research projects that are sponsored may be prescriptive of the goals and findings of the study. Strydom (2002b:70) states that any ethical issues such as the real goal of the study, sponsors and so on must be clarified before commencement of the research.

Although the researcher is employed at Family Life Centre, the study is not sponsored by the organisation in any way. Other than ethical considerations which the researcher will explore with her supervisor at Family Life Centre, it is not predicted that the organisation will be prescriptive of any aspects relating to the study. Any contribution to the study by colleagues will be properly acknowledged.

1.9.4.7 Release or publication of findings

The findings of the study must be released to the public in the form of a written report that accurately and objectively reflects the final results. Any limitations of the study must be mentioned in the report (Strydom, 2002b:72; Grinnell & Williams, 1990:11).

Family Life Centre will receive a bound copy of the final research product which will be available for all staff members, sessional workers and interns/students to peruse.

1.9.4.8 Debriefing of respondents

Debriefing sessions provide respondents with an opportunity to work through the experience of participation in the study and any possible, unforeseen consequences. Strydom (2002b:73) states that the researcher is required to correct any misperceptions that may have arisen as a consequence of the study.

In this study, the researcher will endeavour to ensure that all information is accurately communicated to the respondents at all times. Debriefing sessions may be considered after completion of the study, if deemed necessary by the promoter and supervisor.

Debriefing, if required, will be undertaken by Mrs J. Ramsden, Head of Family Therapy at Family Life Centre, and this information will be included in the consent letters given to the respondents.

1.10 DEFINITION OF KEY CONCEPTS

The key concepts relevant to the study are defined as follows:

1.10.1 Epistemology

Epistemology is the study of knowledge and knowing, and according to Lyddon (1995:579), is concerned with basic questions relating to the "…origins, nature, limits and validity of knowledge". Auerswald (1985:1) defines epistemology as "…thinking about thinking", while Hoffman (1985:324) describes it as "… the study of how we know our knowing". As can be seen from the above descriptions and definitions, epistemology is about cognition and the assumptions inherent in the way we think and make sense of reality. We construct meaning, describe and conceptualise according to our epistemological assumptions. It is thus essential to be aware of our worldview and know what our epistemology is.

1.10.2 Authentic/Self

The *Oxford Dictionary* (1998:25) definition of the term authentic is 'genuine' or 'real'. Genuineness is one of the core conditions of humanistically orientated practice. The person-centred approach to helping was the vision of Carl Rogers, who believed in the health and growth potential of all people. Genuineness or congruence of the therapist is viewed as pivotal in a therapeutic encounter, and facilitation skills become meaningless and even manipulative without it (Van Dyk, 1997:51).

A condition of congruence or authenticity exists when the therapist has explored deeply his/her own self and accepted the revelation of what he/she finds during this journey.

The therapist can be him/herself in any interactions or encounters, and is experienced by others as trustworthy, humane and real. Authenticity requires a high level of self-awareness, self-acceptance and self-trust – it is a way of 'being' rather than a technique. To achieve a level of authenticity requires consistent effort in the drive towards personal and professional maturity (Van Dyk, 1997:53).

The term 'self' is described as a "…compelling sense of one's unique existence…" or personal identity (Reber & Reber, 2001:658-659). These authors describe a number of aspects relating to the self, namely: the self as the inner agent of control over motives, needs, fears, etc.; the introspective quality of the self; the totality of personal experience and expression; the synthesis of the self to form a whole; the self as awareness, consciousness and personal conception; and finally, the self as an abstract goal with the achievement of self as being the final human expression of spiritualistic development.

Authenticity is thus conceptualised as being genuine and real in the therapeutic encounter with a client family, being aware of the self and experiencing congruence between feelings, behaviour and experience.

1.10.3 Reflexivity

Reflexivity is defined by De Vos (2002:369) as the ability to "…formulate an integrated understanding of one's own cognitive world…" with regard to a person's influence and role in human relationships. Reflexivity is linked to the capacity for self-awareness and the ability to empathise, and is, according to Clarke (2002:16), a self-conscious process in the search for honesty and growth.

King (1996:175) quotes Mead's 1934 description of reflexivity as the "…turning back of the experience of the individual upon her or himself…" while more recently, Etherington (2004:19) sees reflexivity as a skill which counsellors develop in their ability to observe their responses and to use that knowledge to inform their actions, communications and

understandings. To engage in reflexivity requires awareness of our personal responses, as well as choice as to how to use them in a therapeutic encounter.

To be reflective is to be contemplative, thoughtful and implies deep thinking (*The Oxford Dictionary*, 1998:344). Reflection is essentially a conscious and cognitive process, thinking about what we already know but opening up the possibility to create new meanings and understandings (Etherington, 2004:28). Thus, although reflective thinking is an aspect of reflexivity, the latter is more concerned with thoughts and reflections about the self as an active agent in the counselling process.

For the purposes of this thesis, reflexivity is defined as awareness and introspection with regard to our personal and professional selves, and the impact of these selves within the context of the therapeutic encounter. Thus it can be seen that authenticity and reflexivity have aspects of commonality, and the one is contingent upon the other.

1.10.4 Family Therapy Theory and Intervention

Family therapy is defined as an umbrella term for a number of therapeutic approaches or models which focus on treating the family as a whole, rather than the individual, in an attempt to promote social functioning (Reber & Reber, 2001:268; *New Dictionary of Social Work,* 1995:25).

Therapy is defined in the *New Dictionary of Social Work* (1995:65) as "…social work assistance which focuses on the emotional and psychological needs of the client". A client may be an individual, a family, group or community to whom services are rendered. The *Dictionary of Psychology* (Reber & Reber, 2001:747) describes the term therapy as a broadly inclusive label for the treatment of disease and disorder, which implies a medical orientation.

The distinction between therapy as defined above, and counselling below, appears arbitrary. Counselling is defined as guidance of the client towards the development of

insight aimed at promoting social functioning (*New Dictionary of Social Work,* 1995:15). In the *Dictionary of Psychology* (Reber & Reber, 2001:162) the definition of counselling parallels that of social work, stating that it is guidance, advice or interviewing aimed at solving problems.

Grinnell and Williams (1990:73) define a theory as a set of interrelated principles developed on the basis of observations, while The *Oxford Dictionary* (1998:431) defines it as a set of ideas formulated to explain something. De Vos and Schulze (2002:40) see the purpose of theory being to explain and predict phenomena, and define a theory as a set of interrelated concepts and propositions that present a systematic view of phenomena by specifying the relationship between the variables. Intervention is defined in the *New Dictionary of Social Work* (1995:35) as professional behaviour intended to bring about change in the client's person-environment situation in order to achieve contractual goals and objectives. In the context of this thesis, intervention refers to work with families based on theoretical constructs relevant to family therapy.

As mentioned in the introduction, the theoretical field of family therapy is extensive and has undergone an evolution from earlier first-order cybernetics through to the postmodern thinking of the present day. Theories on family therapy may be categorised according to behaviour, belief systems and context. These theories will be discussed extensively in Chapter 2.

In this thesis, family therapy theory is conceptualised as intervention with families based on various approaches with specific paradigms that have evolved over time. Family therapy theories attempt to explain phenomena in a scientific and systematic way, although changes in epistemological thinking have paved the way for a belief in multiple perspectives and shared constructions of reality.

1.10.5 Family Therapist/Counsellor/Practitioner

A therapist is defined as an individual trained in and practising the treatment of abnormal conditions (Reber & Reber, 2001:746). The *Oxford Dictionary* (1998:87) lists the word counsellor as a noun pertaining to the definition of counselling (defined in point 10.4), while a practitioner is defined as a professional worker. The term psychotherapist, used in much of the literature, encompasses practitioners from the four mental health professions, namely, psychiatry, psychology, social work and psychiatric nursing (Goldberg, 1986:xxvi).

For the purposes of this thesis, the abovementioned terms used for the practitioner of family therapy will be used interchangeably, since the definitions seem arbitrary and ambiguous. A family therapist is thus conceptualised as a mental health professional that has undergone or is in the process of undergoing training in the field of family therapy.

1.10.6 Postmodern Concepts

To facilitate a clearer understanding of this thesis, various postmodern concepts will be explored and defined.

- **Postmodernism:**

Rivett and Street (2003:31) and Kvale (1992:2) attempt to summarise the relevant features that define postmodernism. 'Postmodernism' (the culture of ideas) and 'postmodernity' (the social embodiment of postmodernism, or the postmodern age) are defined in relation to what is referred to as 'modernist'. Thus postmodern has a definition that relies on the definition of 'modern', which assumes a view that science is built on the basis of observable facts. According to Rivett and Street (2003:32), it is important to note the importance of epistemology, i.e. the theory of knowledge, to the postmodern paradigm. An epistemology reflects the standards to which knowledge conforms to what is taken to be 'true'. Epistemological investigation is a process that emphasises doubt, and such a perspective doubts the validity of what Lyotard (in Rivett

& Street, 2003:32) refers to as 'metanarratives'. A metanarrative is an assumption that dominates Western society and Lyotard terms 'modern' as "…any science that legitimates itself with reference to a metadiscourse … making an explicit appeal to some grand narrative".

In contrast, postmodern is defined by Lyotard as "… incredulity toward metanarratives". Significantly, this scepticism includes incredulity to the metanarratives from which postmodernism evolved, including support for the local rather than the universal, and emphasis on multiple perspectives. Rivett and Street (2003:33) thus define postmodern as an attempt to value all ideas as relevant.

Postmodern is thus conceptualised as a philosophical outlook that argues for multiple views of reality, an absence of universality and a rejection of an objective, empirical reality.

- **Social constructionism/constructivism/narrative:**

According to Rivett and Street (2003:33), social constructionism developed naturally out of the features of postmodernism. McNamee and Gergen (in Rivett & Street, 2003:34) describe social constructionism as views that are "…guided by and limited to the systems of language…" which is a result of "…shared conventions of discourse". Language is seen not only as the medium of communication but the determinant of relationships and future occurrences. Language is a process of social construction that in turn creates narratives. Social constructionism places knowledge in the relational process of social exchange and symbolic interaction that define categories of shared understanding (Gergen in Lyddon, 1995:581).

Social constructionists distinguish themselves from constructivists in that they do not see reality as determined by the individual, but by social structures. Lyddon (1995:581) describes the constructivist perspective as being a knowledge source that focuses on the "…human capacity for imaginative and creative thought", and the construal of reality through language, metaphor, narrative and other symbolic means.

The term 'narrative' refers to a story or discourse, i.e. a conversation in which the person's story is made manifest. The narrative metaphor has provided an alternative interpretation of family therapy, and proposes that people live their lives through stories that provide structure in life (White, 1991:123). Deconstruction challenges problem saturated stories, enabling families to identify and explore alternative possibilities that may generate new and different stories.

Thus, social constructionism focuses on a construction of reality based on social consensus through language, while constructivism emphasises the subjective perception and construction of reality. The narrative approach proposes the construction of narratives that influence the perceptions and worldview of individuals and families.

1.11 CONTENTS OF THE RESEARCH REPORT

The research report contains the following chapters:-

- Chapter 1: General orientation to the study including problem formulation; purpose, goal and objectives of the study; research question; research design and methodology; ethical aspects; and, definitions of key concepts.
- Chapter 2: Literature study: The evolution of family therapy theory, family therapy approaches and the intervention process.
- Chapter 3: Literature study: The reflecting team as a theoretical and experiential component of family therapy training and practice.
- Chapter 4: Literature study: Development and the use of the self in family therapy.
- Chapter 5: Research findings: Qualitative. The research methodology, research findings and conclusions of the study will be discussed.
- Chapter 6: Summary, conclusions and recommendations of the study will be considered with regard to the contribution to be made to the field of family therapy training and practice at Family Life Centre.

CHAPTER 2

FAMILY THERAPY THEORY AND THE INTERVENTION PROCESS

2.1 INTRODUCTION

Scientific theories define the boundaries of a discipline and provide parameters with regard to the subject matter and intervention process. In traditional theoretical approaches to intervention in human behaviour, primarily influenced by Freud, the individual and intrapsychic phenomena were the focus of study. Freud acknowledged the often powerful impact of family dynamics on the individual (e.g. the Oedipus complex) but nevertheless chose to focus intervention on intrapsychic conflicts rather than on family processes (Goldenberg & Goldenberg, 1996:6).

While recognising the significance of individual internal processes and behaviour, the contemporary, broader view of human problems focuses on the family context in which behaviour occurs. According to Anderson (1999:1), the development of family therapy, although not a unified theory or practice, confronts the basic assumptions on which individual approaches were based. Such an interpersonal perspective suggests that human behaviour is part of complex, interactional and recursive patterns taking place within the family, and emphasises the nature and role of individuals within primary relationships (Goldenberg & Goldenberg, 1996:8).

A specific paradigm (i.e. a point of view or philosophy that dominates scientific thinking) defines how a problem is viewed. However, unexplained problems stimulate scientific efforts to develop alternative perspectives and result in scientific revolution (Goldenberg & Goldenberg, 2000:11). According to Goldenberg and Goldenberg (1996:8) and Anderson (1999:2), just such a revolution occurred in the 1950s when

family therapy began. Family therapy represented a new way of conceptualising human problems and of understanding human behaviour, resulting in a paradigm shift. Sluzki (in Goldenberg & Goldenberg, 2000:8) went so far as to consider family therapy an epistemological revolution in the human sciences. The family became the major focus of inquiry, problem explanation and treatment. Successful family therapy was deemed to alter restrictive, self-defeating and recurring patterns, and aimed at enriching family relationships.

Family therapy theory proposed a cybernetic epistemology, initially derived from mechanical systems theory on the regulation of feedback mechanisms operant in controlling both simple and complex systems (first-order cybernetics). Individual behaviour cannot be understood without attention to the context in which the behaviour occurs, i.e. the family. Symptoms function to stabilise the system and relieve family tension (Goldenberg & Goldenberg, 1996:12). According to Golann (1987:331), first-order cybernetics is the "…cybernetics of observed systems…", whereas second-order cybernetics concerns the "…cybernetics of observing systems".

Postmodern theorists advocate a second-order cybernetic view which contends that the individual in the family has a unique, separate, yet legitimate reality. Objective descriptions of families are merely social constructions that are agreed upon through social interaction. Symptoms are viewed as oppressive and the family are assisted to reclaim control and 'reauthor' their lives. This shift in thinking can be seen as a backlash against what were seen as the mechanistic, even manipulative techniques and strategies of first-order family therapists. Central to this perspective is the idea that one cannot observe or describe without modifying and being modified by the subject of observation (Golann, 1987:332).

Goldenberg and Goldenberg (1996:16) state that most family therapists subscribe to some form of cybernetic epistemology, but that a schism has developed between those operating from first-order models where the system is objectively observed and change is attempted from the outside, and those who see the family therapist as part of the

system and a participant in constructing a new reality. Worden (1999:8), on the other hand, views systems theory as a foundation on which to build a new treatment and intervention modality, one that can compliment postmodernist ideas, suggesting a both/and rather than an either/or perspective.

In the literature that follows, the researcher will consider the historical origins of family therapy and trace its development from inception to the present day. The evolution of family therapy, beginning in the 1950s to the present day, will be explored, including the growth of family therapy within the South African context. A concise yet detailed review of the different schools of family therapy will be undertaken. These schools will be categorised according to the central focus of concern, namely theories that focus on behaviour patterns, on belief systems, and on context. Intervention requires consideration of a family's readiness for change, and should be compatible with their culture, beliefs and values. Different forms of intervention will be considered, again using the categories of behaviour patterns, belief systems and context to provide some structure to the many interventions available to the family therapist. Finally, current literature on the notion of integration of modernist and postmodernist thinking will be explored.

The researcher would like the reader to note that the factual content of this chapter is deemed necessary in order to provide the theoretical basis for a better understanding of the epistemological shifts in family therapy. While it may appear to be 'dry' reading, it is an attempt to provide a consolidation of family therapy approaches and interventions, and documents the changes that have taken place over time.

2.2. AN HISTORICAL OVERVIEW OF FAMILY THERAPY

A discussion on the origins and history of family therapy follows.

2.2.1 Historical Roots of Family Therapy

According to Goldenberg and Goldenberg (1996:65), it is difficult to pinpoint accurately the beginning of a scientific endeavour. It appears that the 1950s is identified as the period when researchers and practitioners began to focus on the family's role in the creation and maintenance of psychological disturbance in one or more family members. The cessation of World War II resulted in the reunification of families but escalated a number of social problems for which solutions were sought. People experienced stress as a result of delayed marriages, hasty wartime marriages, the loss of loved ones to death and a boom in the birth rate. Mental health professionals, previously focusing on the individual, were expected to deal with an array of problems associated with families (Gladding, 2002:64; Carr, 2000:48).

Rather than viewing the source of human problems or the appearance of symptoms in one family member as the outcome of one 'sick' person, the family therapist sees that individual as the **symptom bearer**, in other words, the person who expresses the family's disequilibrium or dysfunction (Goldenberg & Goldenberg, 2000:15).

Change in the social environment, such as divorce and sexual liberation brought both freedom and conflict. Concomitant change in the economic, educational and work environments created new tensions for the family. Psychosocial intervention had become more accessible to a wider range of clients and practitioners from a number of disciplines, such as psychologists, social workers, pastoral counsellors and psychiatrists began to offer family intervention processes (Goldenberg & Goldenberg, 1996:66). The scope of intervention was broadened to include such issues as marital conflict, divorce, delinquency and problems with extended family members. Various forms of family intervention were deemed to be effective in treating many disorders, ranging from alcoholism to schizophrenia. More and more practitioners began to recognise the need for family intervention to alleviate family dysfunction and distress (Gladding, 2002:60; Carr, 2000:49).

Sprenkle, Blow and Dickey (1999:329) believe that the field of family (and marriage) therapy began as a "…maverick discipline…", one that was "…oppositional, even defiant…" when compared to the prevailing psychotherapy of the times. Many of the field's founding members were rebels, dynamic and charismatic, who created theories that fitted with their personalities. The various schools accentuated their differences, as well as a belief in the superiority of their approach.

According to Goldenberg and Goldenberg (1996:69), five scientific and clinical developments laid the foundation upon which family therapy was constructed. They are: psychoanalysis; general systems theory; the role of the family in schizophrenia etiology; marital counselling and child guidance; and group therapy techniques. Carr (2000:49-57) concurs, identifying these same developments in the history of the family therapy movement. In order to arrive at a better understanding of the interdisciplinary roots of family therapy, a brief exploration of these developments follows.

2.2.1.1 Psychoanalysis

Psychoanalytic theory and intervention was the work of Sigmund Freud and the dominant ideology in Western psychiatry after World War II, gaining ascendancy within various professions, namely, medical specialities, psychology, social work and sociology. Freud acknowledged the impact of family relationships on the personality formation of the individual, in particular the development of symptomatic behaviour (Goldenberg & Goldenberg; 1996:69). Psychoanalytic theory conceptualised the psychosexual development of children and the use of defence mechanisms as protection from anxiety. Therapeutically, Freud worked with individuals and intrapsychic phenomena rather than with interpersonal family dynamics. Contact with family members was strongly opposed, in the belief that it would 'contaminate' the therapist. This belief changed slowly, mainly for research purposes, and the family came to be seen therapeutically as a group.

Other significant psychoanalytic theorists, such as Alfred Adler and Harry Stack Sullivan began to stress interpersonal influences upon the individual, although it was Nathan Ackerman who has been credited with adapting psychoanalytic concepts to the study of the family (Goldenberg & Goldenberg, 1996:71).

2.2.1.2 General systems theory and cybernetics

This theory, originally presented by biologist Ludwig von Bertalanffy, was an attempt to provide a comprehensive theoretical model encompassing all living systems, and a framework for understanding the interrelatedness of components of larger systems. The traditional view of the time (derived from physical science) was reductionist and linear, while systems theory focused on circular causality and process (Carr, 2000:59; Goldenberg & Goldenberg, 1996:73). In an article that defends linear causality, Dell (1986:513) believes that the insistence on the distinction between linear and circular causality breeds confusion in the mind of the therapist and how they should talk about families. In his view, linear causality refers to two "…distinct and incompatible domains; description (of experience) and explanation". While concurring with Bateson's claim that linear causality is not only impossible but an epistemological error, Dell believes that this does not account for what therapists know experientially, i.e. circular causality does not 'describe' our everyday experiences – Bateson's epistemology 'explains' our experience.

Gregory Bateson, an anthropologist, is viewed by most authors as the single most influential figure in the history of family therapy (Carr, 2000:56). Bateson was not a practitioner of family therapy but researched and developed a unified framework within which mind and material substance could be coherently explained. He formed the Palo Alto group which included Haley, Weakland, Jackson and Fry, who together developed MRI brief therapy. Of particular importance to family therapy were the developments of the double bind theory of schizophrenia, communication as a multi-level process and cybernetics (Gladding, 2002:65; Carr, 2000:57).

The double bind theory proposed that schizophrenic behaviour occurs in families characterised by rigid and repetitive patterns of communication and interaction. Communication as a process conceptualises paradoxical interactions that maintain abnormal behaviour, an example being the double bind theory (Gladding, 2002:65; Carr, 2000:58; Goldenberg & Goldenberg, 2000:86).

Bateson's group combined the concepts of systems theory with insights from cybernetics, the latter being founded by Norbert Weiner, as a framework in which to conceptualise family organisation and processes. From a family organisation perspective, the entire family influences and is influenced by the other members. At the same time a family is part of larger social systems, all being mutually influential (Carr, 2000:59). According to Bertrando (2000:89), the idea of Bateson's cybernetic metaphor has not, as many believe, been to use the analogy of computer science to explain human behaviour within the family system. Rather it is descriptive language to describe human interaction, and possibly to free Bateson and his followers from the psychoanalytic language of the day, and specify their own approach.

Systems theory was historically significant to the emerging family therapy movement, emphasising multiple causality in dysfunction, rather than defining problems as individual intrapsychic conflicts. Of importance too, was the shift from the study of the mind to the study of observable manifestations and behaviours in interpersonal relationships.

General systems theory addressed the question (Carr, 2000:60-67):
How is it that the whole is more than the sum of its part?

Cybernetics addressed the question:
How do systems use feedback to remain stable or adapt to new circumstances?

Significant aspects of general systems theory and cybernetics include seeing the family as a system with boundaries, organised into subsystems; the boundary must be semi-

permeable to allow for adaptation and survival; the behaviour of each family member determines the patterns of interactions that connect the family; these patterns are recursive and may be associated with problematic behaviour; the patterns are circular in causality; family processes both prevent and promote change (i.e. homeostasis and morphogenesis); within the family one member (the identified patient) may develop problematic behaviour which functions to maintain family homeostasis; negative feedback maintains homeostasis and sub-serves morphogenesis; individuals and factions within the systems may show symmetrical and complementary behaviour patterns – exclusive engagement in either pattern may threaten the integrity of the family; positive and negative feedback is "…news of difference" that may enhance change; and, a distinction is made between first- and second-order change (Carr, 2000:66). In the former, the rules of interaction within the system remain unchanged but there may be some alteration in the way they are applied – in the latter the rules within the system change; a distinction is made between first- and second-order cybernetics – the former assumes the therapist is an objective outsider of the family system – the latter assumes the therapist, with the family, forms a new therapeutic system which is influenced by homeostasis and morphogenesis that may impede change or lead to problem resolution; recursive patterns in one part of the system replicate isomorphically in other parts of the system – patterns of family interaction may be replicated across generations and even across social systems. A theory of multigenerational transmission is discussed later in the chapter.

2.2.1.3 The role of the family and schizophrenia

Early studies into the role of family dynamics in the development of psychopathology focused on deficient parenting, specifically the schizophrenogenic mother (cold, domineering, rejecting and possessive) and the detached, ineffectual father, in creating and maintaining pathological behaviour. This was later replaced with the view that pathological interactions occurred within the family context and the connection between family environment and schizophrenia remains at the forefront of family systems research (Carr, 2000: 57; Goldenberg & Goldenberg, 1996:75).

As previously mentioned, one of the major influences in family research into schizophrenia was the work of Gregory Bateson, who together with Haley, Weakland and Fry examined communication patterns in humans and animals. These researchers introduced the concept of the 'double bind', whereby an individual received contradictory messages from significant people, creating an impossible situation of confusion, and hence withdrawal from the relational world. According to Dell (1989:3), there was a deep difference of opinion between Bateson and Haley during the double bind project, with Haley believing that power was central to all human relations, whereas Bateson insisted that the notion of power was "…an epistemological abomination". This disagreement proved irreconcilable and remained unresolved between the two men, although Dell (1989:7) believes that the disagreement on power has been overstated. Bateson's view of power as lineal control and therefore inconsistent with a systemic view fails to acknowledge his complex view that power in any ecosystem or social system will "…inevitably culminate in destructiveness and pathology". Dell (1989:8) believes that when Bateson speaks of power and lineal control he is speaking of a different aspect of power, namely, scientific explanation, whereas most people are speaking of power as experience and description.

At around the same time as Bateson was researching the family/schizophrenia link, Theodore Lidz was exploring the dynamics of the parent's relationship in schizophrenia etiology. Two patterns of marital discord were identified, namely 'marital schism' and 'marital skew'. The former refers to a situation of disengagement and ongoing threats of separation/divorce, while the latter evidences ongoing, destructive marital patterns. This research highlighted the detrimental effects for children growing up in dysfunctional family situations (Gladding, 2002:64; Carr, 2000:55; Goldenberg & Goldenberg, 2000:88; Goldenberg & Goldenberg, 1996:79).

Another researcher during this time, Murray Bowen, was interested in identifying symbiotic mother-child interaction and parental emotional distance in the development of schizophrenia. Gladding (2002:66) describes how Bowen went on to formulate an elaborate theory on the influence of previous generations on the mental health of

families. Succeeding Bowen, Lyman Wynne concentrated on ambiguous and confused communication patterns in family interaction and the concept of 'pseudomutuality' whereby families conceal an underlying distance to defend a sense of meaninglessness and emptiness. In the United Kingdom (UK), R.D. Laing explored the concept of 'mystification' whereby an overt false self develops alongside a private real self which, if reaching a critical level, may result in schizophrenia in families where a person's experiences are consistently distorted, denied and invalidated (Carr, 2000:56).

The commonality in all of the above research is disturbance in family relationships as a major etiological factor in psychopathology. However, as Goldenberg and Goldenberg (1996:81) point out, an obstacle to testing these hypotheses is the fact that the families were studied long after the appearance of mental disorder has disturbed the family system.

2.2.1.4 Marital counselling and child guidance

Goldenberg and Goldenberg (2000:90) describe marital counselling and child guidance as the "…precursors of family therapy", based on the concept that psychological disturbance arises from relationship conflicts as well as inner conflicts. A pioneer in this field of counselling was Emily Mudd (1951), who started the American Association of Marriage Counselors which brought together a number of professionals interested in marital intervention, and led the way for the development of training and practice. Research by Gurin, Veroff and Feld (in Goldenberg & Goldenberg, 1996:82) indicated that while few people sought professional help, (one in seven according to a survey on mental illness and mental health done in this era) of those who did, the majority cited marriage and family problems as the reason for doing so.

Originally a practice without a theory, marital counselling gradually became more formalised. Initially focusing on here-and-now, conscious and pragmatic issues rather than deeper, more intensive psychotherapy, it came to address the affective, cognitive and behavioural aspects of marital relationships within the context of family systems.

The current method for treating marital discord is conjoint therapy, where the couple are seen together by the same therapist (Carr, 2000:50). In the past however, spouses were either seen separately by the same counsellor, or even by different counsellors. In his summary of the developments in family therapy, Carr (2000:50) also identifies the work of Masters and Johnson in the field of sex therapy as becoming integrated into psychodynamic and systemic marital therapy.

Historically, the study of child development really only began around the turn of the 20th century. Changes in social reform and the legal status of children occurred (i.e. compulsory education, restrictions on child labour) and interest grew in providing professional intervention for emotionally disturbed children. Of significance was the innovation of a multidisciplinary team to assess the child and family, usually consisting of psychiatrist, clinical psychologist and social worker. The goals of working with disturbed children and their families were to establish an alliance with the parents to support the child's growth in therapy; gain pertinent information on the family dynamics; and, assist change in the environment (Goldenberg & Goldenberg, 2000:93; Goldenberg & Goldenberg, 1996:85). Such intervention implied family disturbance as a cause of a child's emotional problems.

2.2.1.5 Group therapy

Various forms of group therapy have been practiced since the beginning of the 20th century, but the main thrust of its expansion came from the need for clinical intervention in the period following World War II. Psychodrama techniques were practiced by Jacob Moreno (in Austria) to assist people to recreate situations that may have resulted in psychological problems in front of an 'audience'. These practices were introduced to the USA, and were called group therapy. Similar developments were apparent in the UK, as well as group analysis which focused on helping people understand their self-defeating behaviour patterns, a technique that was included in family therapy (Carr, 2000:52; Goldenberg & Goldenberg, 2000:94).

In Britain at the Tavistock Institute, a number of therapists began to experiment with group intervention techniques. The focus was on dealing with current problems rather than searching the past for trauma and causal factors. Group therapy was seen as a briefer, more efficient way to work with people, and the human potential movement with its use of encounter groups, gained in acceptance and approval by the upper middle classes in the USA - to an extent, therapy was 'normalised' (Goldenberg & Goldenberg, 1996:86). The parallel with family therapy was the fundamental view of group intervention as an agent of change through the influence of its members upon each other.

Gibney (1999:32) believes that while family therapy grew out of a dissatisfaction with previous therapies, it has portrayed itself as a major advancement in practice, ignoring the similarities shared with other therapies, as well as the debt it owes to the influences and origins that have shaped it. His suggestion is that to mature and consolidate its value as a therapeutic discipline, family therapy theory should search for and demonstrate its incongruencies, encourage dialogue, borrow knowledge respectfully, and recognise its influence on our consciousness.

In conclusion, a number of scientific and clinical developments set the stage for the emergence of family therapy. Awareness of the role of the family in personality development, a systemic focus on the family organisation and interaction, marital and family influences on mental health and the development of psychological disturbance, and group processes for therapeutic gain combined to provide a model for family therapy.

2.3 THE EVOLUTION OF FAMILY THERAPY: 1950 – PRESENT

As the developments described in the previous section converged, the field of family therapy embarked on a journey of growth that has yet to reach its peak. Alongside growth, controversy has challenged the assumptions and theories of the field. According to Sprenkle *et al.* (1999:330), the growth of family therapy depended more

on its "…intuitive or emotional appeal…" than on research findings. These authors state that until the mid-1980s family therapy could be described as a "…coterie of competing religions…" and that family therapy consolidated around the charismatic personalities of various theorists. Sprenkle *et al*. (1999:330) quote Lebow who describes the revolution in family therapy that leans towards integration and the move from modernist beliefs to a postmodern understanding of multiple understandings. The following section explores the evolution of family therapy, with attention given to the South African context.

2.3.1 The 1950s:

Consensus identifies the 1950s as the founding decade of the family therapy movement. The motivation for observation of the family was scientific research and the success of this research facilitated the development of therapeutic techniques. This period in the history of family intervention is filled with the names of people who made enormous contributions to the field, and who have become familiar to present day practitioners. These include: Bateson, Haley, Erickson, Whitaker, Satir and many more. From the researcher's perspective it is interesting to note that Carl Whitaker, a psychiatrist, was interested in the use of the self as a tool in the treatment process to achieve more caring and intimate therapeutic relationships, an aspect that was not of noted significance at this time. By the end of the decade the Mental Research Institute (MRI) in Palo Alto was founded, with many well-known family therapists on its staff, while in New York the Ackerman Institute for Family Therapy was organised, both institutes playing a significant role in the field of family therapy (Gladding, 2002:65-68; Goldenberg & Goldenberg, 1996:90).

2.3.2 The 1960s

According to Gladding (2002:66), the decade of the 1960s was an era of rapid growth in family therapy. Interest in the cybernetic concepts grew and many therapists in the 1960s began to work with the entire family in the treatment of psychological disorders.

Those therapists with a more family oriented perspective focused on family structure and interactions, rather than on individual perception, behaviour or affect. The range of family therapy extended to the community and was no longer restricted to the treatment of hospitalised people diagnosed with schizophrenia and their families.

Significant developments in this decade were the founding of the first family therapy journal (i.e. *Family Process*), a number of conferences on family therapy, and growing acceptance of it as an intervention process. In the "…rush to practice…" many practitioners attempted solutions to family issues using the concepts from individual psychotherapy (Goldenberg & Goldenberg, 1996:93). An exception to this was the work of Salvador Minuchin in his pioneering study of urban slum families. His work resulted in the development of a structural family therapy approach that was practical, solution focused and integrative of the social context. A highly productive period followed, with the work of Virginia Satir contributing to the popularisation of the family approach (Gladding, 2002:67; Goldenberg & Goldenberg, 1996:94).

The Brief Therapy Project began at the MRI, geared towards problem resolution and using a primary therapist in consultation with a team observing the session from behind a one-way mirror. Another approach to family therapy was behavioural in orientation, relying on learning theory and derived from empirical studies.

Developments in family therapy outside the United States were of significance. The work of Mara Selvini-Palazzoli, together with Boscolo, Prata and Cecchin, was taking place in Italy and had a worldwide impact on family therapy (Gladding, 2002:69; Goldenberg & Goldenberg, 1996:94).

2.3.3 The 1970s

According to Goldenberg and Goldenberg (1996:95), technique outdistanced theory in family therapy well into the 1970s. A number of therapy approaches were attempted, for example, multiple family therapy, multiple impact therapy and family crisis therapy.

Videotape technology enabled therapists to tape sessions for training and supervision purposes. Gladding (2002:70) sees the 1970s as marked by the growth and refinement of family therapy theories.

It was in this decade that the first attempts at self-examination were made in the field of family therapy. The GAP report (Group for the Advancement of Psychiatry) acknowledged the increased awareness of the family's role in symptom formation, as well as the limitations of traditional emphases on intrapsychic processes. The GAP survey identified the three disciplines mostly involved in family therapy at this time, namely, psychiatry, psychology and social work. Family therapists reported some dissatisfaction with individual interventions, and were interested in more efficient approaches. Some of the goals identified by therapists for treatment included improved family communication, improved autonomy and individuation, and reduced conflict.

The GAP report also explored the influence of major figures in the family therapy field on family therapists. In ranked order were identified: Satir, Ackerman, Jackson, Haley, Bowen, Wynne, Bateson, Bell and Boszormenyi-Nagy (Goldenberg & Goldenberg 1996:96).

As the role of the therapist came to be recognised as significant, a study was made of videotaped family sessions to enhance self-awareness in the practice of family therapy. Two types of family therapists were identified, i.e. conductors and reactors. The former are active, forceful and charismatic, whereas the latter are more subtle, indirect, and less central to the process. Research contended that both categories are effective in family therapy. A further analysis of therapist intervention initiated in the 1970s was neurolinguistic programming, a study of language processes and how these produce change in people.

It would seem however, that most family therapy approaches were never empirically tested or systematically evaluated. A powerful force in the critique of family therapy was the feminist movement, which maintained that a male developmental bias was

insidious in family therapy (Gladding, 2002:71). The social, political and economic context of family life was minimised or even ignored, as were power dynamics between men and women. According to Dell (1989:3), feminists harshly criticised Batesonian epistemology for its failure to address power differences in patriarchal societies, stating that to dismiss power is to deny inequality. A call for conceptual reform forced many family therapists to explore their value system with regard to sex-role stereotypes, and gender based rules and roles.

2.3.4 The 1980s

The 1980s heralded phenomenal growth in the field of family therapy, with a large number of journals published and many family centres in operation (Gladding, 2002:74; Goldenberg & Goldenberg, 1996:100). Goldenberg and Goldenberg (1996:100) state that the social work profession, with its focus on marital and family relationships, can be viewed as an originator of family intervention within the broader field of social casework. In the United States, the professions of social work, clinical psychology and psychiatry formed the basis of many associations connected with the family therapy arena. This view is shared by Carr (2000:51) who identifies the same three disciplines as central to the emergence of family therapy with social work being "…historically privileged…" in identifying family work as an important part of clinical work.

Competing models of family therapy, mostly based on systemic thinking but with differing emphases and perspectives continued the evolutionary process. Videotaped material and workshops facilitated a cross-pollination of ideas. Goldenberg and Goldenberg (1996:101) identify a significant event in 1982 which had far reaching implications for family therapy. This event was a publication of three articles by different authors in the journal *Family Process* that raised important epistemological questions about the theoretical foundation, research models and practice of family therapy. Criticism centred on the acceptance of terminology that failed to define explanation, and on the cybernetic notion of the observer being outside the system being observed. In addition, an overly pragmatic approach which narrowly focused on

behavioural and strategic techniques failed to consider the wider social context in which families live. Hoffman (1990:2) describes how the work of Maturana, Varela, von Foerster and Von Glaserfeld began to filter into the consciousness of family therapists. According to Reimers and Treacher (1995:181), these major challengers to the first-order approach have come from outside the family therapy arena. Maturana (a biologist) believed that human systems are unable to influence one another directly, while von Foerster (a cybernetician) claimed that humans are not mechanistic and cannot be instructed what to do. Von Glaserfeld (a linguist) argued that therapist and client can hope only to create a 'fit' that is adequate for therapeutic purposes. This shift in thinking led the way to a new epistemological challenge, namely second-order cybernetics that was to gain prominence in the next decade.

2.3.5 The 1990s

This decade saw a shift to integration and eclecticism, with the different schools of thought becoming less mutually exclusive. Theories overlapped and there was a degree of 'borrowing' from each other (Goldenberg & Goldenberg, 1996:102). According to Worden (1999:8), systems theory is a fundamental knowledge base that most family therapists share, but theories require refinement and revision, and established perspectives need to be questioned. New and controversial epistemologies, such as constructivism forced family therapists to re-examine systemic assumptions. The new epistemology emphasised second-order cybernetics which extends the focus beyond homeostatic properties of families to belief systems and a worldview. The view of subjective construction and multiple versions of reality suggest that no absolute reality exists, therefore any attempt to change patterns in the family is unpredictable and inexact. Family therapy becomes a collaboration in the context of which family members share their constructions of reality in the hope that increased awareness will facilitate change (Gladding, 2002:75-76: Goldenberg & Goldenberg, 1996:102).

The move to focus on creating meaning through language and having a conversation with families about their problems was led by Paul Watzalawick, Michael White and

Lynn Hoffman, as well as Harlene Anderson and Harry Goolishian. Tom Andersen, a Norwegian psychiatrist, began to use an egalitarian technique called the **'reflecting team'** as a means to stimulate new conversations within the family and to enhance self-awareness and family relationships.

According to Goldenberg and Goldenberg (1996:104), the decade of the 1990s emphasised the fact that family therapy was "…far from monolithic…" and that few beliefs and clinical methods of intervention were universally accepted. The challenge has become to integrate the different approaches in ways that fit with specific client populations.

The phenomenon that was family therapy grew internationally, with training programs and conferences in the United Kingdom, Europe, Israel, Australia and South Africa. According to Kaslow (2000:31), the developments in each country have paralleled those in the United States, with psychoanalysis and behavioural therapy initially dominating theories and interventions. Over time, systemic, strategic and narrative approaches have been introduced and become major approaches to family intervention. Family therapy is influenced by the traditions, needs, beliefs and context of the country in which it is practiced, and in the opinion of the researcher, the complexity of the South African context requires consideration of an 'indigenous' model that suits the requirements of a multi-cultural population. Normative (i.e. Western) ideas of family life and family issues will be relevant to only a small sector of the South African population, requiring consideration by the family therapist of the approach to intervention that will reflect their world view and thus enhance effectiveness.

2.3.6 The History and Evolution of Family Therapy in South Africa

Kaslow (2000:1) writes about the history and evolution of family therapy outside of the United States, with the intention of providing a universal overview of the field which may appear to be dominated by developments in the USA. Kaslow's view is that the current family therapy field "…exhibits a multihued patchwork quilt of many different,

though interconnected, philosophic and theoretical schools of thought". The evolution of family therapy in various countries has followed a similar course, with some deviations reflecting the differing social, political and cultural contexts.

Family therapy in South Africa began in the decade of the 1960s and was conducted by a few professionals who had been influenced by developments around the globe. Mason and Shuda (1996:5) describe how social work in particular became concerned with the plight of the multi-problem family and began to attempt family intervention. According to Kaslow (2000:17), it was initially the academic departments of psychiatry and social work that began to apply the models and techniques of family therapy. In various parts of the country the professions of social work, psychology, psychiatry and psychiatric nursing formed interdisciplinary groups with an interest in family intervention. Landau and Griffiths (in Kaslow, 2000:17) state however, that organisation and communication between professionals was not formalised, and some opposition and resistance to the concept of family based approaches was evident in professional circles.

In 1974, Dr Donald Bloch from the Nathan Ackerman Family Therapy Institute, New York, conducted introductory workshops in family therapy at Tara: The H.Moross Centre, Johannesburg and in Cape Town. The credibility of his analytic background, together with his experience and expertise opened the way for acceptance of family therapy, and lessened opposition. Mrs Jackie Meyerowitz, a social worker from The Johannesburg Marriage Guidance Society, later Family Life Centre, represented the organisation and attended the Johannesburg workshop. Dr Bloch's workshop stimulated interest in family therapy and motivated participants to initiate the South African Institute of Marital and Family Therapy (SAIMFT).

Mrs Meyerowitz was responsible for inviting Dr Bloch to run further workshops at Family Life Centre in 1976. Personal reasons prevented his conducting the planned workshop, however his replacement, Dr Jessie Turberg, stimulated enormous interest in this form of intervention. Coinciding with an expansion of offices from the city centre

of Johannesburg to Parkwood, Family Life Centre was able to specifically designate a suite of rooms for family therapy, with television, video and one way mirrors, in a new wing built onto the existing house (Meyerowitz, 2006).

The University of Cape Town invited Avner Barcai, from the Family Therapy Institute, Israel, to conduct training programs for post-graduate students and practitioners, which heightened interest in the field. By 1976 regional family therapy groups had been formed in the Cape, Transvaal and Natal – the aim of these groups was to foster communication among practitioners and trainees, to provide a review of the literature, and to organise seminars with visiting and local experts (Meyerowitz, 2006: Kaslow, 2000:17-18). Clinical training was dependent on the availability of supervisors within academic departments, although the scarcity of experienced therapists delayed expansion. In addition, certain aspects contributed to a reluctance to refer families for therapy. According to Kaslow (2000:18-19), these included a reluctance on the part of medical aid societies and health care workers, perhaps due to lack of awareness of the benefits of early intervention, or of a perspective of problems existing in a family context, to consider the potential of this form of intervention. At Family Life Centre, family therapy came to be viewed as a much needed form of intervention, and the organisation was fortunate to have the services of Norma Altman, and later Julian Rubenstein, for training and supervision (Meyerowitz, 2006).

The years from 1976 to 1981 saw consolidation and growth in the field of family therapy in South Africa. Since the 1980s extensive education in the form of workshops, conferences and supervision have taken place, bringing a wealth of international knowledge and experience to South Africa. The first international conference of the South African Institute (now Association) of Marital and Family Therapists (originally SAIMFT, now SAAMFT) was held in Durban in 1981, enhancing the credibility and visibility of family therapy. Training continued to be provided at universities, and several professionals visited conferences overseas and presented their work (Kaslow, 2000:20; Mason & Shuda, 1996:6). *Family Therapy in South Africa Today* was the first publication in South Africa of indigenous family therapy research and clinical and

community practice, raising questions regarding the relevance of family therapy in third world communities in South Africa, and the impact of the therapist's stance towards the political aspects of family life (Mason & Shuda, 1996:10).

Throughout the 1980s and 90s and into the next century, many of the distinguished names associated with family therapy theory practice visited South Africa, including Auwerswald, Cecchin, Boscolo, Whitaker, Sluzki, Andersen, White and more (Meyerowitz, 2006; Kaslow, 2000:21). Family Life Centre had the honour of hosting Tom Andersen, as well as Gianfranco Cecchin, and benefited from their experience and wisdom. While practice at the centre is eclectic in orientation, the influences of Michael White and Tom Andersen were strongly felt, and thus a shift to a postmodern paradigm was made. This was especially felt in the practice of the reflecting team, which gradually changed from the approach of the Milan School to one such as described and practiced by Tom Andersen (discussed in Chapter 3).

The past decade has seen major socio-political transformation in South Africa, which impacts on the professions of psychiatry, social work, psychology, law, and medicine. Kaslow (2000:21) believes that it is too soon to assess how family therapy will evolve in the rapidly changing climate that is South Africa.

South Africa is a society comprising many different social, ethnic and cultural groups with considerable socio-economic diversity. The population ranges from the educated and affluent, to the rural and illiterate. In the opinion of the researcher, this provides both opportunities and obstacles to intervention with families in distress, requiring an appreciation of a multi-cultural perspective to facilitate appropriate intervention with diverse client families. While family therapy is undertaken with diverse population groups at Family Life Centre, it is only at the Head Office in Parkwood which has the facilities and personnel resources to deliver this method of intervention. The geographical location attracts the Western or Westernised urban populations. Thus intervention of this nature is restricted to a small sector, and its universal application may not prove to be the most appropriate intervention. The researcher remains

convinced however, of the necessity of this type of family intervention for the population that it does reach. Difficulties concerning the availability of resources and services in wider communities and rural areas remain a challenge.

In conclusion, research into schizophrenia stimulated the family therapy movement which was later influenced by cybernetic ideas as a way of treating dysfunctional behaviour. In the fervour to work with distressed families, many new techniques and strategies were developed, and to a large degree outpaced theoretical development. Rapid growth in the field led to efforts aimed at self-awareness and self-evaluation, these being mainly challenged by feminist critique of sex role stereotyping and gender inequality. A brief period of unity in the 1980s was soon to be challenged by epistemological shifts towards postmodern concepts and a trend towards eclecticism and integration.

2.4 THEORIES OF FAMILY THERAPY

According to Pocock (1999:188), the field of family therapy is extensive and extremely complex, and no simple classification system exists that does not simplify, conceal or subdue many of its nuances. The available literature on the various theories of family therapy is extensive and is classified in diverse ways. For the purposes of this thesis, the researcher intends to follow the classification system of Carr (2000) which organises the many schools of family therapy according to the central focus of therapeutic concern, namely: theories that focus on behaviour patterns; theories that focus on belief systems; and theories that focus on context (Carr, 2000:69). Table 2.1 presents a brief overview of the classified theories.

Table 2.1: Classification of schools of family therapy according to central focus of therapeutic concern.

Behaviour Patterns	**Belief Systems**	**Context**
MRI Brief therapy	Constructivist	Transgenerational
Strategic therapy	Original Milan school	Psychoanalytic
Structural therapy	Social constructionist	Attachment-based
Cognitive-behavioural therapy	Solution-focused	Experiential
Functional therapy	Narrative	Multisystemic
		Psychoeducational

Adapted from Carr (2000:70)

The concise sketches of these schools of family therapy that follow may not do justice to the contributions each approach has made to the extensive and fascinating field that is family therapy intervention. For those readers interested in discovering an approach that has an authentic 'fit' with their sense of self, a more thorough exploration is recommended.

2.4.1 Theories that focus on Behaviour Patterns

As can be seen from Table 2.1 the theories that fall into this category include the MRI brief therapy approach; strategic family therapy; structural family therapy; cognitive-behavioural family therapy; and, functional family therapy.

2.4.1.1 MRI brief therapy

Carr (2000: 76) identifies the principal figures in this school as Weakland, Watzlawick, Segal, Bodin and Fisch. The Mental Research Institute was founded by members of Bateson's group in the 1950s and the Brief Therapy project was set up in 1967. MRI

brief therapy is a pragmatic integration of cybernetic and systemic concepts, the hypnotherapy approach of Milton Erickson, and von Foerster's constructivism.

The central idea of the MRI approach is that ineffective attempts to solve problems result in maintaining the problem. The MRI research identified individual symptoms as a reflection of family dysfunction, maintained by the family system (Carr, 2000:76; Goldenberg & Goldenberg, 1996:211). Cybernetic concepts such as feedback loops and circular causality are basic to MRI thinking and therapy. The MRI team developed a series of brief, specific and symptom-focused interventions aimed at problem resolution. The approach is pragmatic, aimed at understanding the behaviour and finding solutions that change dysfunctional family rules, expose hidden agendas and modify paradoxical communication patterns (Goldenberg & Goldenberg, 1996:215).

An important concept introduced in the MRI approach is the level of change. **First-order change** does not change the structure of the system and change may be superficial and of short duration. **Second-order change** requires a fundamental alteration of the system's structure and function. The rules of the family system are altered, resulting in change to the system itself. According to Watzlawick (in Goldenberg & Goldenberg, 1996:215), therapy must accomplish second-order change, often achieved through the use of reframing of the therapeutic double bind.

The **therapeutic double bind** is a term for a variety of paradoxical techniques used to change persistent problematic family patterns. The client is told to change by remaining unchanged – he or she cannot fail to react to it but cannot react in the usual, symptomatic way. **Prescribing the symptom** is a way of urging the family to continue the practice of the symptoms, or even to exaggerate them in an effort to undermine resistance to change. This challenges the function of the symptom and assists the family to find new ways of interacting. **Relabeling** attempts to alter the meaning of a situation so that it is perceived differently by the family (Goldenberg & Goldenberg, 1996:218).

Assessment focuses on tracking problematic behaviour patterns and ineffective solutions, while intervention attempts to disrupt these problem-maintaining behaviour patterns through paradoxical suggestions to refrain from trying to solve them. According to Carr (2000:81), the MRI approach does not specify an articulate model of functional and dysfunctional families, but involves the view that a more flexible, adaptable family will avoid becoming trapped in ineffective cycles of problematic behaviour.

Interviews are conducted with the people who most want to change – there is no requirement for the whole family to attend therapy. However, the conceptual framework involves identifying others trapped in the repetitive cycle of interaction. The MRI model distinguishes between 'customers' who are committed to solving their problems and 'window shoppers' who are attending treatment to satisfy someone else. Historical, constitutional and contextual factors are of little significance in assessment, which typically involves a step-by-step description of how a problematic episode begins progresses and concludes.

Treatment aims at achieving small but noticeable change that differs from the status quo, and is maintained and expanded through positive feedback (Carr, 2000:82). Restructuring family organisation or facilitating personal growth is not the focus of MRI therapy. Therapy sessions are the forum for developing and reviewing tasks carried out between sessions. Promoting change, rather than focusing on the process within the sessions, is the primary aim.

The role of the therapist is strategic, with a high level of control over the therapeutic process. The therapist may even strategically withhold information about the cybernetic and systemic rationale underpinning intervention (Carr, 2000:83). However, to encourage clients to work harder at resolving problems, the MRI therapist may take a one-down position, claiming uncertainty or helplessness in understanding the attempts of the family at various solutions. Use is made of **therapeutic restraint**, advising clients to 'go slow' to avoid making the situation worse through the use of impulsive,

inappropriate solutions until a firm foundation for change is laid. Therapeutic restraint typically has the paradoxical effect of accelerating change – increasingly cautious invitations to exercise restraint are met with increasing bold attempts to resolve a problem. An exploration of the dangers of quick resolutions, doubt about their permanence and predictions of relapse may further accelerate positive change. All change is credited to the family and not to the therapist. Termination may occur with an expression of puzzlement at the family's rapid progress rather than celebration. Requests for work on other issues may be met with the suggestion to allow for consolidation of change already made (Carr, 2000:84).

From the description of the type of intervention above, it seems to the researcher that the family therapist practicing MRI therapy would have to feel comfortable with a degree of duplicity and pretence, as well as a firm belief in the necessity of the therapeutic double bind as a technique to assist the family to achieve the desired second-order change. If this approach is to be used effectively, the family therapist needs to know if he/she can authentically put the techniques into practice, and if they are congruent with values and the self. From the researcher's perspective, inauthentic use of such techniques could be perceived as 'phoney' by the family, and thus prove ineffective or worse, damaging.

A related MRI strategy is to request clients to list the negative consequences of change in the early stages of therapy, and to explore these if intervention is met with resistance – again, the paradoxical effect of this may defuse resistance to change. Problems may be reframed in ways that the client can accept as plausible, and unique interventions are constructed in each case to disrupt problem-maintaining behaviour.

MRI therapy has been influential in casting human problems as interactional and maintained by the family system. Therapy aims to break the cycle of repetitive and destructive behaviour patterns and provide solutions to rapidly resolve problems in ways that change the family system.

2.4.1.2 Strategic family therapy

The founder of strategic family therapy was Jay Haley, a member of Bateson's group and co-founder, with Cloe Madanes, of the Washington Family Therapy Institute. The central theme of strategic family therapy is that the family is ambivalent about change because the problem serves some function for family members – the problem is viewed as a strategy when other attempts at resolution have failed. The therapist must design specific interventions to undermine this ambivalence and help the family resolve the problem, while at the same time provide an opportunity to deal with the complex interpersonal issues the problem functions to serve (Carlson & Kjos, 2002:81; Carr, 2000:86; Thompson & Rudolph, 2000:325; Goldenberg & Goldenberg 1996:224).

Within strategic therapy it is assumed that healthy families have clear intergenerational boundaries, can adapt to the family life cycle stages with flexible rule and role changes, and have effective problem-solving skills. It is also assumed that within family relationships there are both complementary and symmetrical transactions, and that love is the central value of the family.

In contrast, the problematic family is characterised by an unclear boundary structure, a lack of flexibility in moving through the life cycle stages and relationships being exclusively either **complementary** or **symmetrical**. It is argued that differing hierarchical structures and coalitions may occur in families which may be denied and can lead to **pathological triangles** which may hinder progression through the life cycle stages. Relationships, particularly marital relationships, may be characterised by exclusively symmetrical transactions (e.g. persistent arguments) which have the potential to create unremitting conflict, or exclusively complementary transactions (e.g. caregiving) which inevitably become problematic over time (Carlson & Kjos, 2002:85; Carr, 2000:87).

Carr (2000:88) describes Madanes' conceptualisation of family difficulty as arising from attempts to control/to dominate; to be loved/to love and protect; to repent/to

forgive. Associated problems include aggression, delinquency and abuse; depression, anxiety, eating disorders, suicide and thought disorders; sexual and physical abuse.

In the first interview with a family, all members are expected to attend. Assessment in strategic therapy involves identifying the specific problem with which the family want help; clarifying the pattern of interaction around the problem; clarifying family hierarchy roles, life cycle 'stuckness' and reliance on symmetrical or complementary transactions. Family difficulties as described above are also addressed. The assessment interview has four sections – the first section consists of a **brief social stage**; understanding the perspective of each family member of the problem and its process; exploring previous attempted solutions and the effects of these. In the second stage or **problem stage** of the interview the therapist conveys the problem as one embedded in patterns of family interaction. During the third **interaction stage** the family are encouraged to explore the differing views they share concerning the problem, whilst the therapist observes any coalitions, power hierarchies and so on, and develops some hypotheses about future intervention. The final section of the initial interview is the **goal setting stage** whereby therapy goals are specified and defined in concrete ways that will be measurable over the course of the therapy (Carr, 2000:89; Thompson & Rudolph, 2000: 330; Goldenberg & Goldenberg, 1996:227).

Treatment in strategic family therapy consists of the therapeutic team formulating problems, reframing these for the family and providing **directives** that will disrupt the pattern of interaction which maintains the presenting problem. According to Madanes (in Goldenberg & Goldenberg, 1996:228), the directive is to strategic therapy what interpretation is to psychoanalysis – it is the "…basic tool of the approach". A directive is an instruction from a family therapist for the family to behave differently (Gladding, 2002:223). Therapy sessions focus on reframing, giving directives and reviewing progress. Change is assumed to occur between sessions, as it is then that the problem maintaining patterns occur.

Paradoxical directives are designed to provoke defiance and may reveal the secondary gain inherent in the symptomatic behaviour. Haley (in Gladding, 2002:224; Goldenberg & Goldenberg, 1996:230) extensively taught the use of the therapeutic paradox to bring about change. Three stages are identified in designing a paradox, i.e. redefining, prescribing and restraining. Before the therapist can 'prescribe the symptom' the behaviour must be redefined as a loving gesture in the service of preserving family stability. The wording of the prescription must be concise, brief and unacceptable, the latter in order for the family to recoil from the instruction. The therapist must appear sincere in offering a convincing rationale for the prescription. When indications of change become evident, the therapist must restrain the family from accelerated change to preserve homeostatic balance (Hanna & Brown, 1999:221; Goldenberg & Goldenberg, 1996: 231).

A less confrontational intervention is **pretend techniques** (Madanes in Goldenberg & Goldenberg, 2000:241; Goldenberg & Goldenberg, 1996:231). These are paradoxical in nature but less likely to invite defiance, although still effective in overcoming family resistance. Based on humour, fantasy and metaphor, pretend techniques strategically help families abandon symptomatic metaphors and open up the possibility of attempting more adaptive ones.

Treatment encompasses several stages – building a relationship with the family, defining the problem, setting goals and making a concrete plan, issuing directives and observing the response. The role of the therapist in strategic family therapy is authoritative and active – the therapist is responsible for changing the family organisation and resolving the problem the family has brought to him/her through intervention that overcomes the family's homeostatic tendencies (Gladding, 2002:225; Jurich & Johnson, 1999:202; Goldenberg & Goldenberg, 1996:226).

From the perspective of the researcher, the family therapist using strategic therapy would need to be comfortable with the responsibility of making decisions relating to what the family needs to do to change, as well as with giving directives. In particular,

the use of paradoxical directives requires a high level of self-awareness from the family therapist, as well as a firm conviction in the need for this form of intervention.

Criticism of strategic therapy relates to its manipulation and authoritarian aspects. The use of techniques such as paradox can be damaging if used by inexperienced practitioners, and as such requires considerable training (Gladding, 2002:227). In addition, strategic therapy is said to lack collaborative input from the family, emphasising expertise and therapist responsibility for change. Haley (in Goldenberg & Goldenberg, 1996:231) dismisses such criticism and believes that all therapies rely on therapist influence and expertise to resolve family problems, but that most fail to acknowledge their power.

In summary, typical characteristics of the strategic approach to family therapy are the use of paradoxical techniques aimed at changing family rules, disrupting dysfunctional patterns and promoting change through compliance or resistance.

2.4.1.3 Structural family therapy

Structural family therapy was primarily the work of Salvador Minuchin and his colleagues, developed in response to a sense of disappointment with psychoanalytic therapy with working class clients. The central idea in structural family therapy is that problematic family organisation may compromise the ability to adapt to life cycle change, unpredictable family stressors or broader, external stressors (Aponte & DiCesare, 2002:2; Carr, 2000:91; Thompson & Rudolph, 2000:320; Jurich & Johnson, 1999:201). A family's **structure** is the set of 'rules' or functional demands that organise the way the family members interact with one another. Such a structure provides a framework for understanding the consistent and enduring patterns that maintain family stability, as well as adaptability to changing conditions (Gladding, 2002:201; Goldenberg & Goldenberg, 1996:191).

Within structural family therapy, healthy families are presumed to have a structure that is flexible in accommodating life cycle transitions. The **intergenerational boundaries** that exist between the family subsystems require definition and clarification, and according to Thompson and Rudolph (2000:320), families who understand the difference between healthy and unhealthy subsystem boundaries function more successfully. Such boundaries should be neither rigid nor diffuse, and functioning should be neither chaotic nor rigid. Subsystems function to organise the family according to criteria such as gender, generation, common interests, or task – many permutations may exist and each member belongs to several subgroups at the same time (Goldenberg & Goldenberg, 1996:193). The strength of the parental subsystem is significant in family stability and flexibility, and according to Jurich and Johnson (1999:196), many families do not have a balance of subsystems or even an executive (parental) subsystem, thus the potential for dysfunction escalates.

Emotional closeness requires a balance between **enmeshment** and **disengagement** (Carr, 2000:92; Worden, 1999:19; Goldenberg & Goldenberg, 1996:195). With enmeshment of family members, there is extreme proximity, intensity and over-involvement – separation and autonomy is viewed as betrayal. Subsystem boundaries are weak and poorly differentiated. At the other end of the continuum disengaged families are autonomous but have little sense of family loyalty or togetherness. Disengaged families struggle to provide support when needed, while enmeshed families find difficulty in permitting autonomy and are over-involved in one another's lives. Disengagement and enmeshment are strategies for avoiding conflict, either through preventing any discussion of change or denying any difference.

Coalitions refer to alliances between specific family members against a third member and can be an important determinant of family function or dysfunction. A strong parental coalition is often beneficial to effective child rearing, while a parent-child alliance may undermine family functioning. In some instances, conflict may be detoured through the child, a process referred to as **triangulation** - such triangulation may lead to psychosomatic responses. A weak parental subsystem may give rise to a

'parental child' or parentified child, who functions in a parental way, while a rigid hierarchy may fail to take childrens' needs into account. A dysfunctional family cannot fulfil its function of facilitating the growth of its family members (Gladding, 2002:202; Carr, 2000:92; Goldenberg & Goldenberg, 1996:196).

Clear boundaries allow family members to enhance communication and relationships through dialogue and corrective feedback. According to Jurich and Johnson (1999:192) the family must define who it includes and excludes. In entering counselling, a family with **rigid boundaries** and a preconceived definition of their family create a closed, inflexible system that may prevent new information, options and resources from entering and challenging the family system. Overly **diffuse boundaries** encourage dependence and may result in family 'members' changing on a daily basis, with implications for counselling. Boundary problems may cause difficulties or families may become more extreme in their boundary styles either as a defence or coping technique (Gladding, 2002:203; Jurich & Johnson, 1999:194).

Assessment and treatment occur concurrently in structural family therapy. Members of the family and even people from the wider social system, if deemed significant, are invited to join the first session. Therapy begins with the **joining** of the therapist and clients to form a therapeutic alliance – Minuchin (in Goldenberg & Goldenberg, 1996:203) emphasised the importance of accommodating the style of the family and facilitating an atmosphere of safety in which to explore areas of pain and stress. **Tracking** refers to gaining an understanding of each member's description of the problem, life themes, values and significant family events (Gladding, 2002:205; Hanna & Brown, 1999:180; Goldenberg & Goldenberg, 1996:203).

Gladding (2002:206) specifies **disequilibrium techniques** aimed at changing or perturbing the system so as to reduce 'stuckness'. **Enactment** is a "…staged effort…" by the therapist to bring family conflict into the open in order to reveal the family structure, strengths and flexibility (Gladding, 2002:207; Goldenberg & Goldenberg, 1996:205). Through enactment the therapist encourages family members to jointly

attempt problem solving, perhaps even coaching family members to deal with difficult transactions or to try different solutions – the therapist actively avoids being inducted into problem maintaining interactional patterns which are part of the family dysfunction. **Unbalancing** is a procedure wherein the therapist allies with an individual or subsystem, thus forcing the family to relate differently to that person or subsystem. A focus on **process** is seen as more significant than on **content**, with the former needed to unbalance and restructure the family (Carr, 2000:93).

Reframing is a technique that is intended to change the original meaning of a family event or situation, and place it in the context of an equally plausible explanation – the aim is to provide a more constructive view, altering the way it is perceived. From a structuralist perspective, reframing relabels the problem as a function of the family structure (Gladding, 2002:206; Hanna & Brown, 1999:215; Goldenberg & Goldenberg, 1996:205). In the opinion of the researcher, this technique has a postmodern flavour, since it aims to alter the family member's belief about an event or problem. This suggests perhaps, that integration of modern and postmodern concepts is not out of the question.

The technique of **restructuring** is central to the structural approach – it involves changing the structure of the family by altering the existing hierarchy and interaction patterns so that problems are not maintained (Gladding, 2002:208). Structural interventions may increase stress on the family system and unbalance family homeostasis. However, they may open the way for transformation of the family structure through emphasis that the problem belongs to the family and not the individual 'symptom bearer'. In restructuring the family rules, members learn alternative ways to deal with one another and with conflict, increasing the growth potential of all the members.

From the perspective of the researcher, the nature of the structural approach to family therapy requires an enhanced understanding of family dynamics, not only those of the client family, but also those of the therapist's own family-of-origin. Knowledge of

one's role in one's family-of-origin, intergenerational boundaries and various systems and subsystems would be necessary, particularly if there are any similarities in the client family. Such similarities could result in the therapist being 'inducted' into the family system, thus compromising intervention if similar dynamics are replicated.

The structural family therapist is both observer and expert, using interventions to modify and change the underlying structure of the family and assist the family to unite in a healthy and productive way (Gladding, 2002:209). Criticism focuses on the approach being inadequate to address the complexity of family life; reinforcing sex role stereotypes such as executive roles for husbands and expressive roles for wives; focusing of the present and ignoring historical data; and disempowering for the family since the therapist initiates change.

In conclusion, structural family therapy focuses on family subsystems, boundaries and coalitions and the manner in which dysfunctional structures require renegotiation. Priority is given to insight into problem behaviour within the context of the family structure. Structural interventions are active, even manipulative on occasion, the aim being to change dysfunctional patterns and realign the family organisation.

2.4.1.4 Cognitive-behavioural family therapy

Cognitive-behavioural family therapy evolved from the work of Gerry Patterson on behavioural parent training which used the principles of social learning theory to modify behavioural problems. Work on cognitive-behavioural marital therapy came from Richard Stuart's contingency contracting for conflicted couples, and intervention in both these domains has grown extensively over the years (Carr, 2000:94; Goldenberg & Goldenberg, 2000:265; Goldenberg & Goldenberg, 1996:253).

The central assumption of cognitive-behavioural family therapy is that problematic behaviour and cognitions are learned and maintained by repetitive patterns of interaction. **Imitation, classical conditioning** and **operant conditioning** are all factors

relevant to the acquisition of these patterns. The aim of therapy is to interrupt problem maintaining patterns through the coaching of skills that perpetuate healthy behaviour and challenge negative cognitions. Maladaptive behaviour can be 'unlearned' and replaced with new learned behaviours (Gladding, 2002:172; Goldenberg & Goldenberg, 2000:266; Hanna & Brown, 1999:29; Goldenberg & Goldenberg, 1996:257).

Social learning theory attempts to integrate the basic principles of learning with an understanding of the social context in which learning takes place. Vicarious learning occurs through observation of the behaviour of others, as well as the consequences of that behaviour. This offers a broader perspective than conditioning theories of learning and is seen as more appropriate to family behaviour. Through **modelling** the therapist or even a family member can provide an example of the behaviour to be imitated, which then becomes part of the client's behavioural repertoire. Maladaptive behaviour, rather than the underlying causes, is seen as the target for change (Gladding, 2002:193; Goldenberg & Goldenberg, 1996:257).

Family therapy may or may not include all family members and will seldom involve extended family members – the focus in more on the individual with behavioural symptoms than on the family as system that is always active in symptom maintenance. The approach is more linear than circular with regard to causality, although some cognitive-behavioural family therapists do have a more systemic perspective in their view of family dynamics (Gladding, 2002:175; Goldenberg & Goldenberg, 1996:260). The role of the therapist is of expert and teacher who assist the family to modify or change cognitions and interactions. The role requires persistence, patience and energy (Gladding, 2002:187).

Research within the cognitive-behavioural school shows relationship differences between distressed and non-distressed families. In distressed relationships, family members engage in more negative interpersonal patterns of behaviour that are mutually reinforcing and which often maintain defiant and aggressive behaviour problems with children and between couples. In addition, **negative cognitive schemas** dominate the

thinking patterns of the family members – such schemas involve selective attention, attributions and assumptions based on negative thinking and behaviour patterns (Carr, 2000:95).

Assessment in cognitive-behavioural family therapy entails an analysis of problematic issues in the family, involving monitoring of duration, frequency and intensity of both negative and positive interactions as well as their antecedents, related cognitions and consequences. **Behavioural checklists** and psychometric questionnaires may be used to evaluate cognitions. Goals are aimed at increasing positive and reducing negative interactions, cognitions, feelings and behaviours (Carr, 2000:95; Goldenberg & Goldenberg, 1996:259).

Cognitive restructuring is an intervention technique aimed at modifying thoughts and perceptions, and is based on the idea that faulty cognition gives rise to dysfunctional behaviour (Goldenberg & Goldenberg, 1996:257). Cognitive restructuring is the principle intervention used to challenge negative cognitions – this involves a change in belief systems and is, according to this approach, the only way of effecting permanent change. The intervention involves monitoring situations that create certain cognitions, assessing the impact on behaviour and mood, and challenging them by finding ways to refute or support them – if no evidence supports the cognition, clients are challenged to find new cognitions to fit the evidence.

A large number of techniques are used in treatment in cognitive-behavioural family therapy. With children, these include reward systems to increase positive behaviour and time-out to reduce negative behaviour. **Contingency contracts** may be used with adolescents or between couples, and involve an agreement about the consequences of certain behaviour – contracts may be of a quid pro quo nature, where specific positive behaviours are linked with consequences for both parties. Alternatively, contracts may be based on good will or good faith, where positive behaviour is specified but not linked to consequences (Gladding, 2002:193; Carr, 2000:96; Jurich & Johnson, 1999:200). Other techniques include **problem-solving** wherein problems are defined

and broken down into smaller solvable parts, solutions evaluated and modified if necessary; **communication training** where clients are coached through modelling and role-play to communicate more effectively; **role-play** whereby family members are asked to "act as if" they are already the person they want to be; and **coaching** of families to engage in more appropriate responses and positive behaviours.

The researcher is of the view that this approach to family therapy requires an active and energetic therapist who is at ease with his/her role as expert and teacher. The focus on behaviour and cognition, and the discounting or minimising of emotional aspects implies a degree of intellectualising of problems which may feel more comfortable for some family therapists who may become overwhelmed by the complexity and intensity of family emotion. Again however, a high level of self-awareness is called for, knowing what fits for the self to facilitate authentic practice.

Gladding (2002:189) states that cognitive-behavioural family therapy is less systemic than many other approaches – learning is focused on individual or subsystem behaviour and thus may hinder complete family change. Feelings are not the focus of therapy and although family members may change behaviour, they may not feel or think differently. The approach favours family action over family insight and does not explore family dynamics sufficiently. In addition the approach is criticised for being rigid in application, which may result in losing rapport with the family. There is little emphasis on building and maintaining a therapeutic alliance, nor on process over problem identification and solving.

Cognitive-behavioural family therapy is an attempt to bring a scientific method to intervention with families experiencing problems, through monitored procedures based on social learning and the influence of cognition on family interactions.

2.4.1.5 Functional family therapy

Functional family therapy is an attempt to combine behavioural family therapy with aspects of strategic and structural family therapy, based on the observation that families often find cooperation in cognitive-behavioural family therapy difficult (Carr, 2000:97; Goldenberg & Goldenberg, 1996:276). The belief is that families firstly need to understand the function of the behaviour in their interactions. Therapy is aimed at replacing problematic behaviours with non-problematic behaviours that fulfil the same function in relationships.

For the functional family therapist, all behaviour is adaptive, serving a function in an effort to create a specific outcome in interpersonal relationships. Goldenberg & Goldenberg (2000:289; 1996:276) differentiate between three interpersonal states that family members strive to achieve: contact and closeness (**merging**); distance and independence (**separating**); and a combination of the two (**midpointing**). By understanding the interpersonal functions served by the problem behaviour, the therapist can help the family find alternative ways to achieve the same result.

Functional family therapists use some systemic and behavioural principles in intervention. **Relabeling** is used to provide new meaning to causes of behaviour that will lead to changed perceptions and thus behavioural change. Education is deemed necessary in order to provide the context for learning skills needed to maintain positive change. To achieve change, the functional family therapist uses a variety of cognitive-behavioural techniques, such as contingency contracts, modelling, and communication training to enhance family functioning (Carr, 2000:98; Goldenberg & Goldenberg, 1996:278).

Functional family therapy aims to integrate systems, behavioural and cognitive theories in working with families. The view that all behaviour serves an interpersonal function for the family implies that change is required of the behaviour that maintains these

functions. The eclectic feel of this approach may appeal to the family therapist who is confident in working with an integrated approach.

The five theories of family intervention described above focus on identifying problem maintaining behaviour patterns and attempts to disrupt them. Strategic and structural models emphasise the importance of the organisational structure of the family in contributing to family dysfunction, while all of the approaches, with the exception of structural, focus on problem resolution as the primary goal. Personal growth is not of major concern with these approaches, and treatment tends to be brief.

In the following section, the approaches emphasise the role of belief systems in patterns of family interaction.

2.4.2 Theories that focus on Belief Systems

In the section that follows the focus is on theories that emphasise belief systems serving patterns of family interaction. These are: constructivism; the Milan School; social constructionism; solution-focused family therapy; and, narrative family therapy (Carr, 2000:110). Controversy exists however, about the place of the Milan approach, with some authors seeing it as more strategic in nature, while others question its apparent similarities, believing them to mask deeper differences (McKinnon, 1983:425). According to Goldenberg and Goldenberg (2000:300), the developments of the Milan approach has moved it towards a second-order cybernetic viewpoint – a post-Milan position. This collaborative position provides a link to postmodernism, and the theory focuses on enabling the family to give meaning to how their lives and family organisation are defined.

The approaches described below share a rejection of positivism and a commitment to an alternative epistemology (Carr, 2000:110). In order to grasp more adequately the epistemological shift that connects these theories, a brief exploration of this shift will be

undertaken, before moving on to a discussion on the theories of family therapy that focus on belief systems.

2.4.2.1 Epistemology: positivism, constructivism, social constructionism, modernism and postmodernism

Although defined in Chapter 1, the above concepts will be examined in relation to the family therapy theoretical arena.

- **Epistemology:**

Epistemology is the study of knowledge. However, Bateson used the term more loosely to refer to an idea that the universe, both material and non-material, is a single ecological system made up of an infinite number of subsystems. Following the more informal use of the term epistemology within the family therapy field, Carr (2000:111) describes it to mean a specific theory of knowledge or worldview. According to Rorty (1980:316), to construct an epistemology is to seek common ground, assuming that such common ground exists. The claim to an epistemology can be fiercely debated in an academic context and is beyond the scope of this thesis.

Distinction is made between three epistemologies, namely, positivism, constructivism and social constructionism.

- **Positivism:**

Positivists argue that our perceptions of the world truly reflect how it is – a single reality may be directly perceived. Family therapy from a positivist position assumes that there is a single 'real' definition of the problem which may be discovered through assessment and resolved through the use of scientifically proven techniques. The therapist is the 'expert' on the true nature of the problem. The usefulness of positivism in family therapy lies in the development of assessment and intervention that has been scientifically tested. However, according to Carr (2000:115), the outcome of these

studies is useful to social constructions rather than to objective truth. In other words, they represent our shared constructions of events, and not necessarily reality.

Positivism is associated with a number of related positions, namely: empiricism – true knowledge is gained through the senses; representationalism – perceptions are accurate representations of the world rather than personal or social constructions; essentialism – objects and/or events have an essential nature that may be discovered as opposed to multiple meanings that may be given to objects and/or events; realism – belief that there is one real world rather than multiple personal or social constructions (Carr, 2000:115).

- **Constructivism:**

The constructivist argument is that individuals construct their own representations of the world through their senses, information-processing capabilities and belief systems. This personal construction of the world is influenced by characteristics of the individual and the environment (Mills & Sprenkle, 1995:369). Radical constructivists (such as Maturana and Von Glaserfeld) accord priority of perception to individual characteristics while constructive alternativism, advocated by Kelly, emphasises both environmental and personal contributions to perception (Carr, 2000:116). Carr goes on to suggest that radical constructivism poses a problem for family therapy, rendering communication and cooperation within the family meaningless in the face of such predominantly individualistic perception. Kelly's view on the other hand suggests similar, shared worldviews within the family as influenced by a common environment but with an individual, unique interpretation of events.

Within the field of family therapy radical constructivism has influenced the MRI approach (Von Glaserfeld and von Foerster), while the Milan systemic school has been influenced by Maturana who argued that families will only adapt their problematic situations in ways consistent with their physiological and psychological structure – the therapist can only 'perturb the system' but not direct it to change in any predictable manner (Carr, 2000:116; Mills & Sprenkle, 1995:369).

Kelly's personal construct theory, constructivist family therapy and aspects of the cognitive-behavioural tradition are grounded in constructive alternativism. This epistemological stance affects therapeutic practice in a significant way – each family member's view of the problem is unique and valid, although some constructions lend themselves to more effective problem-solving. Self-defeating attributions may be replaced with more empowering beliefs. Of value to the self-reflective process of the therapist is the degree to which we hold beliefs about a family from their behaviour, or from our own theories and professional 'prejudices' (Carr, 2000:117).

Minuchin (1991:48-49) writes on the " …seductions of constructivism" and claims that in denying the legitimacy of expertise and developing interventions aimed at avoiding 'control', constructivists are proclaiming themselves as the "…new crew of experts". He believes that the theoretical concepts of constructivist therapy, i.e. a neutral, curious, and non-directive stance, the idea that objectivity is impossible, that language creates reality rather than merely reflects it, and that all truths are reached through social consensus, have produced little in the way of how to put theory into practice when intervening with real families with real problems. A further criticism is the inclination of constructivist therapists to focus exclusively on the idiosyncratic story and ignore the social context that impacts on life, e.g. socio-economic conditions, the realities of age, illness, gender, race and class.

- **Social constructionism:**

The social constructionist position, popularised by Gergen, argues that individual knowledge of the world is socially constructed through language, family and culture. An evolving set of meanings emerge from social interactions and form part of a constantly changing narrative (Atwood, 1995:10). As with constructivists, the social constructionist accepts that individual perception is determined in part by the objects/events themselves, and in part by the person's physiology and psychology – however there is emphasis on the influence of social interaction within the person's community which occurs through the medium of language. The truth is constructed

rather than discovered, by communities in conversation – constructions that do not prove useful are discarded (Carr, 2000:117; Mills & Sprenkle, 1995:369).

Golann (1987:334) states that a large and relatively unexplored area exists between the recognition of constructed realities and the appreciation that all realities are not equal with regard to degree of consensus. He argues that some events can be interpreted more reliably, or with higher consensus that others, and that all subjective descriptions are not equally valid when moving from the individual to the group level. There is a range of consensus in the way events and the environment is described, and reality should not be dismissed as an illusion. Critics of social constructionism argue that the philosophy is inherently negative and that if human behaviour is constrained by social interactions, language and behaviour, then there is no possibility of alternatives and hence, change (Rivett & Street, 2003:35).

Social constructionism is endorsed by Milan systemic therapists, including Cecchin and Boscolo, Lynn Hoffman, Tom Anderson's reflecting team approach, Anderson and Goolishian; by solution-focused therapists such as deShazer; and by narrative therapists such as White and Epston (Carr, 2000:118).

In relation to family therapy, social constructionists co-construct with clients more useful ways to describe the problem that opens up the possibility of alternative solutions. The therapist's stance is one of uncertainty, and questions are used as interventions, allowing for the possibility of alternative non-problem definitions (Atwood, 1995:15). Carr (2000:118) believes that this is the "…most coherent epistemology" for family therapy and family therapy research since the results are not objectively true, rather they are useful social constructions developed through conversation. Hoffman (in Reimers & Treacher, 1995:189) summarises the main points of second-order, social constructivist thinking: an observing system position and inclusion of the therapist's own context; collaborative rather than hierarchical; goals that emphasise a context for change without specifying change; a circular view of the problem; a non-judgmental view.

Central to the social constructivist paradigm is the "…relational, dialogical and generative nature of knowledge and language" (Anderson, 1999:3). This view influences the notion of transformative or dialogic conversations, which is active, collaborative and allows clients both to be heard and to contribute.

- **Modernism and postmodernism:**

The positivist theory of knowledge is an integral part of the modernist movement, whereas postmodernism, associated with constructivism and social constructionism, arose in response to the perceived failure of modernism that had promised freedom from superstition through science and reason. Modernism assumes the existence of universal laws discovered through systematic, empirical investigation. Knowledge would be value-free, rational and scientifically progressive (Carr, 2000:119; Polkinghorne, 1992:147).

The postmodern transformation began in response to scepticism regarding modernist assumptions, questioning the belief in value-free objectivity, and deconstructing modernist discourse as no more than " …ungrounded, historically-situated rhetoric" (Carr, 2000:119). The notion of a single objective and rational account of the world is rejected – the world is socially constructed by communities of people. In Bertrando (2000:88) the postmodern therapist views the cybernetic position as mechanistic, failing to do justice to the "…humanity of 'human systems'". However, Bertrando (2000:89) goes on to state that analogies to computer science were not the intention of Bateson – the cybernetic metaphor is not a metaphor but is descriptive language used to distinguish their approach and free themselves from humanistic psychoanalytic language. A misuse of cybernetic models may result in a reification of computer metaphors that were never the intention of the originators.

Postmodernism challenges taken-for-granted assumptions (deconstruction) and meta-narratives, and reconstructs people's stories in more empowering ways (Goldenberg & Goldenberg, 1996:306). A meta-narrative is defined by Sim (1998:315-316) as any theory claiming to provide universal explanations and to be universally valid.

Collaboration between therapist and family members is participatory, assisting the family to co-construct alternative stories or new outcomes (Goldenberg & Goldenberg, 2000:299).

Postmodernism has implications for family therapy. Gergen (in Carr, 2000:119) states that no single true model of family therapy may be constructed. Rather, certain problems and contexts lend themselves to particular models, while empirical research results are not reflections of the truth but are socially constructed statements by researchers in conversation that may prove the use of particular therapies with specific problems in certain contexts. In addition, contextual variables such as gender, patriarchy, culture, class and ethnicity must be incorporated into useful models of family therapy because there are no universal principles for good practice (Goldenberg & Goldenberg, 1996:303).

According to Kvale (1992:6-7), discussions on postmodernism become entangled with modernist "…polarities of thought…". Postmodern is a descriptive term, depicting what comes after modernism. The term is not anti-modern, implying an undermining of modernism - rather it re-uses concepts and recycles them in new contexts. A postmodern discourse leads to re-conceptualisation of subject matter, thus opening new avenues for social sciences. Kvale (1992:200) sees contradiction in the implied anti-modernist stance of the postmodernist, and goes on to state that it is impossible to delineate clearly between modern and postmodern. However, this issue is fraught and complex and is not within the domain of the current argument. For the purposes of this thesis the trend in postmodern psychology of questioning, reframing and allowing numerous possibilities is helpful in the formulation of a family therapy framework within a multicultural South African society.

Bertrando (2000:92) suggests that the postmodern approach has "…its own internal inconsistencies" which create difficulties and paradoxes. To accept all narratives as equally valid and therefore equally true, is to take a position of being obliged to **not** take a position, i.e. to disregard theory. Bertrando (2000:93) goes on to state that

postmodern thinkers such as Derrida and Lyotard did not deny the existence of some sort of reality, but rather encouraged systematic doubt regarding one's premises and theories (metanarratives). Postmodern therapists run the risk of turning doubt into a certainty, thus being modernist. For the researcher, the issue is perhaps one of openness to shifts in thinking, and a questioning of our own position of certainty with regard to knowledge and its meaning for the families we encounter.

According to Held (1995:4-5), the single position that unites the many manifestations of postmodern thought is a rejection of realist epistemology in favour of an anti-realist stance. Realism suggests that knowledge can be attained objectively and independently – it is not merely a cognitive, linguistic or theoretical construction on the part of the knower. The anti-realist principles that form the core of linguistic philosophy, and thus postmodern theory, radically alter what is commonly accepted to be the nature of truth. Truth is a construction in language situated in particular discursive contexts (Held, 1995:8-9). Held (1995:9) makes the point that anti-realism, as with realism, contains more than one formulation – for extreme anti-realists there exists no independent reality other than our own mental constructions. According to Rivett and Street (2003:46), Held is the most consistent critic of the postmodernist anti-realism perspective. These authors discuss an article by Held (2000) which suggests that anti-realism leads to a stance of being anti-theoretical – this position is defended as the individualisation of therapy. According to Held (in Rivett & Street, 2003:46-47), the two positions have no connection – anti-realism can only support individualised practice if the client's perspective is one of realism. Furthermore, the anti-realist stance prevents family therapists from being involved in research which will help them to understand how best to help the client family. Held (in Rivett & Street, 2003:47) believes that it is only through empirical observation that the family therapist can determine what is or is not evidence of successful treatment.

The modern position adheres to the realist doctrine which is characterised by general laws and truths obtained by way of reason, science and technology, the determinacy of meaning and the subject having a real existence (Held, 1995:9). The postmodern view

which is fundamentally anti-realist is, in contrast, characterised by a rejection of general laws and truths, an espousal of plurality of meaning and a denial of the real existence of the subject (Held, 1995:10). Cognitive representations of the world are historically and linguistically mediated, therefore truth is local, specific and transitory. In her critique of postmodernism, it is the belief of Held (1995:14) that the postmodern movement diminishes the complexity of theories of therapy and has failed to generate knowledge concerning what causes problems and what creates solutions. The practitioner is 'free' to focus on the unique circumstances of each client, without the burden of having to know and apply a vast amount of theory and research. From the perspective of the researcher, the family therapy practitioner is required to have knowledge of theory – however the way in which interventions are implemented is the issue. Do they come from a position of certainty, or are they possibilities that may or may not have meaning and create change for the family?

Implications for practice from a postmodern perspective include a rejection of the idea of a true 'diagnosis'; a single definition of the problem or solution; the view that the therapist's view should be privileged over the client's. The therapist is no longer the outside 'expert' on the family's problem, prepared to manipulate or instruct the family to behave in certain ways. Multiple perspectives and solutions are sought, aimed at finding useful outcomes that are provisional and tentative, with collaboration between family and therapist. Language is the medium or "…therapeutic vehicle" for creating meaning and co-constructing more empowering stories to create new ways of coping in the family (Goldenberg & Goldenberg, 1996:305).

In the opinion of the researcher this has clear implications for the practice of family therapy in South Africa, where multi-cultural and cross-cultural contexts are evident.

Family therapy approaches that explore constructivist, social constructionist and postmodern ideas as a basis for practice will be considered in the section that follows.

2.4.2.2 Constructivist family therapy

Carr (2000:120) positions constructivist family therapy within the personal construct theory of George Kelly. The core assumption of this theory is that people develop constructs or beliefs to enable them to anticipate events – a personal construct system may change as experience suggests modifications that may lead to more accurate predictions. The constructive therapist acknowledges that we are looking at events through "…lenses…" and that how we look determines what we see and do (Hoyt, 1998:2).

Change in construct systems occurs where new experiences make new aspects relevant, and according to Kelly (in Carr, 2000:121), peripheral and permeable constructs are more accessible to change than are core constructs that define a person's identity and which change more slowly.

Of relevance to family therapy is the view that people choose marital partners who they believe will help them to elaborate on their construct systems so that their world becomes more predictable and understandable. Families develop shared construct systems which are validated or invalidated by the collective behaviour, interactions and dialogues within the family. These shared belief systems play a role in organising patterns of family interaction, and are originally negotiated by the marital couple with the influence of their own family-of-origin constructs and idiosyncratic interpretations of the dominant cultural construct system (Carr, 2000:121). Where family construct systems are too tight (e.g. rigid, enmeshed families) or too loose (e.g. chaotic families) or where life cycle transitions invalidate the family construct systems, symptoms may occur. Fixed belief systems influence not only what people perceive, but also how they analyse, interpret and give meaning to their perceptions (Goldenberg & Goldenberg, 1996:307).

In constructivist family therapy the position of the therapist is both collaborative and expert. Clients and therapist collaborate on the articulation of the family's personal

construct systems and test the accuracy of the predictions that form the bases of their constructs – clients are the experts on the content of their constructs. The therapist is the expert on the process of facilitating exploration of the constructs and in designing useful ways of testing and revising them (Carr, 2000:122; Goldenberg & Goldenberg, 1996:304).

Assessment and intervention phases are not clearly defined in constructivist family therapy. However some techniques that are more assessing in nature are: **laddering**, a method of discovering hierarchical constructs that define the family identity; **circular questions**, as typified by the Milan school; the **Repertory Grid Test** (REP) is a paper and pencil or computerised method used to elicit constructs using triadic questioning, and useful as a basis for therapeutic conversations regarding the revision of construct systems; **self-characterisation** as a method of identifying core constructs; **autobiographical sketches** of the relationships, transitions, and so on, which may reveal differences and similarities in the constructs; the use of **metaphor** to best fit the family or presenting problem (Carr, 2000:124).

The role of the therapist is aimed at facilitating constructive revision so as to help client families to develop constructs that lead to more accurate predictions. Intervention may be directed at reviewing role and inaccurate constructs that may impact on predictions and thus on behaviour. According to Carr (2000:125), resistance is viewed as the product of inaccurate therapeutic constructs which entail the belief that clients should exhibit cooperative behaviour under certain conditions. From the perspective of the researcher, this approach seems to require a flexibility with regard to the personal constructs of the family therapist. In other words, an awareness of one's own constructs and the predictions which ensue is necessary, both to avoid 'knowing' what the family's issues are, and to facilitate a process of change.

Thus, the constructivist approach focuses on personal and family constructs that may contribute to problem-development and -maintenance.

2.4.2.3 Milan systemic family therapy

One of the unique features of the Milan approach is a concern with systemic or circular understanding of the family and the problem (Gladding, 2002:229; Goldenberg & Goldenberg, 1996:304). The Milan theoretical perspective, with its second-order cybernetic implications that the therapist is part of the system being observed, has strongly influenced postmodern family therapy. Carr (2000:126) as well as Reimers and Treacher (1995:182) describe the Milan school as split into at least two sub-traditions – one with its commitment to the original strategic approach (Selvini-Palazzoli and Prata), the other committed to a more collaborative social-constructionist approach (Boscolo and Cecchin). The latter has been most influential in the USA.

In practice, the original Milan family therapy team meet before the initial session to hypothesise on the basis of information gained telephonically. **Hypotheses** are formulated around the presenting problem, problem-maintaining interaction patterns and family belief systems. During the interview these hypotheses are tested by eliciting the perspective of each family member and observing interaction patterns. Cecchin (1987:412) sees hypothesising as "…suspending the search for one explanation" and challenging our own beliefs and descriptions.

Circular questioning aims at constructing new information about the situation that challenges prevailing belief systems that maintain problematic interactions. Circular questions focus attention on family connections through framing differences in perception by family members concerning events or relationships. A position of neutrality is taken by the therapist, in contrast to structural family therapy which aims to unbalance the family and restructure it (Gladding, 2002:230; Carr, 2000:127). According to Cecchin (1987:412), circular questions are "…nurtured by curiosity" and provide the possibility of undermining the belief system of the family that is based on accepted 'truths'. Reimers and Treacher (1995:191) support the view of questioning as facilitative, but suggest that all forms of questioning, including circular, may be construed by the family as judgemental and experienced as distancing, unempathic and

even punitive. The power of the therapist is evident in his/her ability to dominate the session through questioning – thus an egalitarian therapeutic relationship cannot be built on the basis of questioning.

A team using the Milan approach will meet again mid-session, to discuss the relevance of the hypotheses and synthesise information into a systemic hypothesis regarding symptom-maintenance, recursive patterns and underlying beliefs within the family. **Positive connotations** are attributed to the behaviour of all family members – behaviour is labelled as benevolent and motivated by good intentions (Gladding, 2002:230). Tasks may be assigned by the team and given to the family by way of a message. Finally, the team has a post-interview discussion. Family resistance to therapy may be handled through the expression of "…therapeutic impotence…" on the part of the team, suggesting that the family problems are too complex and intervention too risky to consider (Carr, 2000:128).

In this original model of family therapy, the process described above is typical. Around the 1980s a split occurred, with the original approach developing strategic aspects to the model and developing the concept of 'family games', i.e. problem-maintaining interaction patterns whereby family members stabilise around disturbed behaviours in an attempt to benefit from them. According to Reimers and Treacher (1995:183), the crucial difference between the two groups hinges around the issue of 'neutrality' which these authors believe Palazolli to have abandoned. The family games are often described as 'dirty' with family members displaying 'subtle cunning', 'manipulation', 'treachery' and 'relentless revenge'. While this may be seen as dehumanising, Reimers and Treacher (1995:183) explore an explanation by Selvini and Palazolli which claims their approach guards against the therapist supporting or even reinforcing a pathogenic family process. The **invariant prescription** is a standardised directive, aimed at breaking the power struggle between generations. Failure by the family to comply with this prescription may result in termination of therapy (Gladding, 2002:231; Carr, 2000:129).

The assignment of **rituals** is an attempt to break up dysfunctional rules in the family. They are a type of prescription that directs family members to change their behaviour under certain circumstances, and thus change the meaning of the behaviour (Gladding, 2002:231).

In Milan systemic therapy, the therapist is both an expert and co-creator of an "…evolving family system". Overt challenge is avoided, with the therapist rather taking a paradoxical position of "…change agent who argues against change" (Simon in Gladding, 2002:232). As the family evolves, the 'old epistemology' is discarded and more productive behaviours emerge.

Criticism of the approach focuses on the neglect of historical patterns of family interaction, change that focuses on behaviour in favour of insight, and the use of teams which adds to cost in terms of human resources (Gladding, 2002:237). The researcher experiences a sense of discomfort at some of the aspects of the Milan systemic approach, specifically the reference to 'family games' which hint at judgment and criticism of the family's attempts to cope with life. However, it is clear that becoming involved in a perpetuating cycle of problematic beliefs is of little or no benefit to either the client family or the process of change. Again, self-awareness and reflexivity are essential to both chosen approach and practice.

In conclusion, Milan systemic family therapy uses a team approach to help families solve problems, using innovative techniques designed to change behaviour and thinking.

2.4.2.4 Social constructionist developments

In contrast to the directive strategic aspects within the original Milan approach, Cecchin and Boscolo developed a style based on social constructionist premises. From this perspective the stories of the individuals within the families are not necessarily owned by the individual – they may be family stories or cultural stories.

The use of **circular questioning** allows the therapist and family to co-construct multiple perspectives relating to the problem – within these perspectives are possibilities for problem resolution. As originally devised, circular questioning was a powerful tool for the therapist, but as previously stated, Reimers and Treacher (1995:186) suggest that this form of questioning may be controlling, distant and uninvolved. Boscolo evolved the system of circular questioning to a more future focused exploration of new belief systems about problems and solutions and the idea of creating new realities. Emphasis has shifted with regard to the position of the therapist and approaches to circular questioning (Carr, 2000:129).

Cecchin expanded the concept of **neutrality** to include **curiosity,** i.e. multiple explanations of a problem, and **irreverence** toward the therapist's frame of reference, 'pet' theories and biases. Neutrality is seen as the creation of a position of curiosity in the mind of the therapist, leading to the exploration of alternative views. Curiosity opens up new ways of viewing a problem and is a stance not only for the therapist but for the family. It involves not being too attached to any one hypothesis or explanation, but to engaging in conversation that opens up the possibility of new perceptions (Carr, 2000:129; Reimers & Treacher, 1995:186; Cecchin, 1987:405-406).

Other significant developments within the social constructionist movement include the work of Karl Tomm's interventive interviewing, Tom Andersen's reflecting team approach and Harlene Anderson's collaborative language approach (Carr, 2000:130). These developments will be considered briefly:

- **Interventive interviewing:**

Tomm developed new ways of conceptualising the position of the therapist and the therapeutic use of questioning. Interventive interviewing refers to circular questioning guided by strategies, which in turn refers to clarifying the intention of asking particular questions. Four main types of intent are identified: **investigative** (to gain information); **exploratory** (to uncover patterns); **corrective** (to direct clients to behave in various ways); **facilitative** (to open up new possibilities).

Also distinguished are four types of question which correspond to the four intentions: **lineal** (inquire about problem definitions and explanations); **circular** (inquire about patterns of interaction); **strategic** (direct and confrontative); **reflexive** (suggest new possibilities) (Carr, 2000:131; Worden, 1999:82-84).

- **Reflecting team:**

The reflecting team approach will be explored in depth in Chapter 3 of this thesis. However, for the sake of continuity, its position in social constructionist theory will be touched on.

According to Carr (2000:131), Andersen, using conversation and collaboration, developed new ways of giving the family a message from the team during the session. The family are given the opportunity to observe the team members explore the family interview, listening to reflections that focus on family strengths and ideas that open up possibilities of problem resolution. The family and primary therapist resume the session, discussing useful ideas and observations gained from the reflecting team. This cooperative, egalitarian approach contrasts with the original Milan team which was more secretive, strategic and allowed no possibility for clarification or discussion. The attitude of the reflecting team is tentative, respectful, positive, accepting and non-judgmental.

Reflections may explore the problem situation, possible solutions or hypothetical future scenarios, constructs of family members, and non-verbal processes that may be outside the awareness of the family (Carr, 2000:131; Goldenberg & Goldenberg, 1996:319; Mills & Sprenkle, 1995:373). According to Dallos and Urry (1999:177) the discussions in front of the family offer not only some new stories, but also an opportunity to hear different ways of talking about their situation.

- **Collaborative language systems:**

Anderson and Goolishian developed a unique social constructionist approach to family therapy, abandoning systemic and cybernetic frameworks and replacing these with the

notion of collaborative language systems. People converse about problems and either co-construct them or 'dissolve' them through language (Carr, 2000:132, Mills & Sprenkle, 1995:370). Therapy is seen as an opportunity to change the family system through dialogue that opens up the possibility of new interpretations. Anderson (1999:4) refers to this as a dialogic conversation that involves talking, thinking and listening – listening is active, reflective and participatory. Change is the evolution of new meaning through dialogue (Anderson & Goolishian, in Hoyt, 1998:5).

Minuchin's critique of language systems suggests that the privileging of language over experience is limiting, and that an understanding of people includes emotions such as anger, anxiety, pleasure, fear, and many more which tend to silence or obscure language (Minuchin, 1999:13). Held (1995:1-2) states that the linguistic paradigm is part of a broad, intellectual movement in the humanities and social sciences, based on a sense of inadequacy with modern scientific approaches. This author believes however, that the theoretical and applied implications of postmodernist theories have not received serious and comprehensive scrutiny or critical evaluation.

Returning to the discussion on social constructionist developments, the approach distinguishes between **problem-determined systems** and **problem-dissolving systems**. The former refers to people who agree that a problem exists and whose belief maintains the problem – this may include family members as well as others in the social network, such as teachers, health care professionals and so on. The latter in contrast, refers to the therapist in collaboration with the problem-determined system who believe there is a problem and who dissolve the problem through the 'therapeutic conversation'. The role of the therapist is non-expert, non-hierarchical and collaborative – the client's view is privileged as much as the therapist's. Respectful listening that does not consciously hypothesise or strategise is used to generate dialogue and explore multiple constructions of the problem and solution to create new meanings. Conversations and co-constructions are conducted in the client's language rather than using jargon and technical terms (Carr, 2000:132; Goldenberg & Goldenberg, 1996:315; Mills & Sprenkle, 1995:370).

Considering the issue of expertise, Anderson (1999:5) believes that there is space for therapist expertise, but that this is not an observing, judging or instructing expertise that is an agent of change or that rescues 'victims' from dominant discourses. Instead, the therapist's expertise involves creating a space for dialogue and participation in a dialogical process - expertise and wisdom are co-created in this space, responsibility is shared, and the therapeutic relationship is less hierarchical, and more collaborative. Taking a 'not-knowing' position refers to how a therapist positions him/herself in relation to the clients and how he/she responds and interacts with them. What we think we know is held in doubt, offered as one possibility amongst many, and without the need to be right. Not-knowing does not mean that we have no opinions, views or information – it is being open and honest about our thoughts, while providing a place for the uniqueness of people's experience. Anderson (1999:6) believes that the imposition of theoretically determined bias limits or closes dialogical conversation.

In contrast, Minuchin (1999:13) believes there is room for "…benign expertise…" which is not used to silence clients' voices, nor does it represent an abuse of power. Bertrando (2000:92) also criticises the not-knowing position, stating that it is impossible to adopt a true not-knowing position, because the therapist cannot avoid knowing her own experience, and when faced with any new situation, will inevitably remember a theoretical position or hypothesis based on similar situations. It is a "…simulation…" of not knowing, pretending not to have a viewpoint. The researcher is of the opinion that Anderson does not refute expertise, but rather holds knowledge as a possibility, rather than a certainty. This implies being open to alternative interpretations by family members, and respecting their position on an issue. In keeping with postmodern family therapy, this would thus allow for a multiplicity of meanings, realities and solutions, rather than maintaining the therapist's knowledge as a metanarrative.

Tomm elaborated on the Milan school's interviewing techniques, while Andersen developed new ways of giving families a message mid-session. Anderson and

Goolishian focused on the position of the therapist in relation to the clients and on language and conversation to develop new possibilities and solutions.

More well-developed are the solution-focused and narrative approaches to family therapy, also based on a social constructionist world view, to be considered next.

2.4.2.5 Solution-focused therapy

Solution-focused therapy developed as an approach to work with a wide range of client populations. The emphasis is on strengths and positives using culturally based resources, and is respectful of cultural and social differences. Intervention is seen as an empowering, collaborative enterprise. Developed by de Shazer and his associates, solution-focused therapy is concerned with change rather than the historical antecedents of family problems. Led by the therapist but directed by the client's goals, dialogue focuses on solutions to be constructed together to reach these goals. The approach capitalises on the concept of "…news of a difference" and its purpose is to engage in a therapeutic conversation with the family that is conducive to solution-building (Lee, 2003:390; Carr, 2000:133; Mills & Sprenkle, 1995: 371).

Dysfunction in a family arises from faulty attempts at problem resolution. Within the therapeutic encounter, attention is given to circumstances where the problem does not occur, and the assumption is that clients know how to solve their problems. The role of the therapist is to help them construct a new use for the knowledge they already have but are not using. De Shazer and Berg (1992:80) describe how meanings are negotiated in the face-to-face encounter with the family, and how in the understanding of these meanings, new solutions are developed. They warn however, that this activity is not a technique – rather it is spontaneous and natural, requiring of the therapist an awareness of the possibilities for change so that a shift in meanings can lead to the development of useful interventions that fit the family and are pragmatically aimed at the family's goal for therapy.

The line between assessment and therapy is not clearly drawn in solution-focused therapy. Assessment, such as it is, may begin with inquiries about the problem, the position of clients with regard to the problem, and view of the role of the therapist with regard to problem resolution. A distinction is made between 'visitors' (clients who are sent to therapy at someone else's request), 'complainants' (clients who accept they have a problem but are unwilling to participate), and 'customers' (clients who accept they have a problem and want to change). These positions are not fixed and clients may move from one to another over the course of the therapy (Gladding, 2002:247; Carr, 2000:134).

The idea of resistance is based on the view that people have unique ways of cooperating, not all of which conform to the therapist's expectations. To promote cooperation, tasks must be selected to fit clients' readiness to change – these may be complimentary (empathic statements), observational (observing exceptions or occurrences of successful coping) or behavioural (doing more of what works or doing something different) (Gladding, 2002:244; Goldenberg & Goldenberg, 1996:313).

Assessment is also relevant regarding **exceptions**, i.e. where/when the problem did not occur, or was less intense, and in articulating goals for problem resolution. **Outcome questions** help clients to envisage life without the presenting problem or with acceptable improvements. The '**miracle question**' is a typical outcome question used to assist clients to visualise a better outcome to their problem. **Scaling questions** can be useful to measure more abstract change, such as feelings and mood. **Relationship questions** ask clients to imagine how significant others in their environment may react to solutions and changes to be made. The use of **skeleton keys** helps families to 'unlock' a variety of problems by using strategies that have worked in the past and have universal application. The brevity of the model (usually five to ten sessions) creates the expectation of change – small changes, once initiated, may lead to changes in the system (Lee, 2003:390; Gladding, 2002:245-246; Carr, 2000:133-135; Thompson & Rudolph, 2000:119-126; Goldenberg & Goldenberg, 1996:310-312).

A positive, optimistic and hopeful perspective regarding problem resolution, respect for the client's problem-solving resources and simple therapeutic techniques form the basis of solution-focused therapy. It encourages, challenges and sets up an expectation of change (Gladding, 2002:248). Criticism of the approach centres on it being too simple, too brief and reliant on suggestibility with long-term change being unlikely. Some recent developments indicate a more affective and relational aspect becoming part of solution-focused intervention. Further criticisms include the absence of historical information about the family and an exclusively present focus of concern.

From the perspective of the researcher, this approach lends itself to work with families who may have an alternative worldview to that of the therapist, hence its applicability to postmodern, multicultural intervention. It requires too however, a degree of comfort with the unknown, and with taking a 'bottom up' approach to the development of solutions that suit a particular family, thus making the expert position redundant.

Solution-focused family therapy aims to help the family seek solutions to problems and tap into unused resources and potential. Change involves constructing a different perspective in collaboration with the client family through the use of questions that reinforce small, but specific gains in problem resolution.

2.4.2.6 Narrative therapy

Michael White and David Epston are the originators of the narrative approach to family therapy, influenced by the postmodern movement within anthropology, philosophy, psychology and feminist theory. Narrative counselling uses the story metaphor to understand the meanings people construct about themselves on the basis of their lived experience in the world (Gladding, 2002:252; West & Bubenzer, 2002:355; Monk, Winslade, Crocket & Epston, 1997:85).

Discourse theory is part of the postmodern approach to knowledge whereby 'master' or metanarratives and universalising themes are perceived as constricting. Dominant

discourses are produced through social interaction, language and the socio-economic context (Hare-Mustin, 1994:20). They are familiar, taken for granted and reinforced through assumption of their validity. Subordinate discourses on the other hand, are marginalised and subjugated. Hare-Mustin (1994:21) draws attention to the work of White, which emphasises how power is often invisible to those who experience it and to how people are led to "…embrace their own subjugation through the influence of presumed truths". This quote and the views of White which follow, have immense resonance for the researcher within the context of family therapy practiced at Family Life Centre. Families are often referred from other organisations and have been 'labelled' or diagnosed in various ways, labels which often seem to be accepted by the family without question. People seem to accept 'expert' discourses which have the power to create 'problem' individual and family identities.

White (in Carr, 2000:137) rejects the traditional concept of individually based problems and the use of the systemic framework which has characterised almost all forms of family therapy. Using the work of Foucault as a frame, White refers to the process of diagnosing clients and the resultant labels which come to constitute their identity as 'totalizing techniques'. In addition, the keeping of files written in the context of pathological and deficit discourses promote the construction of **global** knowledge which undermines **local** knowledge. Scientific knowledge typically entails the exertion of power or social control over clients, and White questions the ethics of practices that privilege global knowledge and totalizing techniques, resulting in the development of **problem-saturated** identities (Carr, 2000:137). Bertrando (2000:90) states that the discourse of Foucault on power, two decades before the rise of narrative therapy, is completely different from narrative thinking linked to political criticism and power relations, and that one does not have to be a narrative therapist to be concerned with issues of power. If, as Foucault may have put it, power is a network of connecting relationships, rather than the intention of an individual, the very fact of being a therapist and asking questions puts one in a position of power (Bertrando, 2000:91). The researcher would, however, argue that from a dialogical point of view, questions arising

from the therapist are part of the dialogue, and not necessarily a misuse of power in the therapeutic encounter.

Lyddon (2001:581) emphasises the narrative or story as the central organising principle for human understanding from a narrative perspective. Humans create order and meaning through the stories they tell one another. However, many of the narratives people accept are socially determined (dominant) and thus, may constrain individual freedom and self-expression. Morgan (2000:13) believes that certain discourses may give rise to thin conclusions (elucidated below) which may negatively affect peoples' lives. People (and families) become disempowered, and may be labelled dysfunctional or inadequate.

According to White (in Carr, 2000:137), when families are conceptualised as systems with interpersonal problems viewed as serving a particular function (family homeostasis), the goal of therapy is to discern the function of that problem and replace it with a less destructive routine that fulfils the same function. This system analogy entails the view that some families are dysfunctional and require the problem to remain intact for homeostasis. It implies also, that their behaviour is a requirement rather than a personal choice. In contrast, narrative therapy privileges the ability of the individual to choose his or her personal narrative.

When the 'game' analogy is used to understand problematic family interaction, members are seen as using moves and countermoves to win the 'game'. Strategies are used to end the game, with the therapist using deception in the form of paradoxical intervention to bring about this result. Narrative therapy uses an open, collaborative partnership with clients, avoiding the use of deception and power practices (Carr, 2000:138). However, as has been pointed out, power is an inescapable fact of life and efforts to avoid it may serve to drive it underground, where its impact may be more dangerous through being unacknowledged.

Morgan (2000:2) describes narrative therapy as a respectful, non-blaming approach which focuses on people as the experts on their own lives. Narrative therapy does not distinguish between problem and non-problem family development, rather its focus is on problem development. In narrative therapy the person is not the problem, the problem is the problem (Morgan, 2000:2; Monk, *et al.* 1997:26). The technique of externalisation (defined below) to dysfunction in the narrative approach may thus diffuse the argument above that power is an inescapable fact of life. Rather than ignoring the power relations inherent in therapy, narrative therapy rather empowers the therapist and the client over the problem, by labelling the problem as the problem, rather than the client as dysfunctional and thus powerless.

Human problems, from a narrative perspective, arise from and are maintained by oppressive stories which dominate people's lives. These are referred to as **thin descriptions**, which according to Morgan (2000:12) limit complexity and contradiction in life and obscure other possible meanings. To be freed from the influence of limiting discourses it is not enough to re-author an alternative story. The narrative therapist is interested in finding ways in which these stories can be "…richly described…" giving rise to **thick descriptions** (Morgan, 2000:15).

Narrative therapists are interested in discovering, acknowledging and taking apart the beliefs, ideas and practices of the broader social system that may serve to assist the problem story. **Deconstruction** is the crux of narrative family therapy – clients are helped to explore and create different interpretations of their story, and challenge accepted and dominant texts that subjugate their lives (Rivett & Street, 2003:37; Morgan, 2000: 45; Mills & Sprenkle, 1995:371; White, 1991:121).

A central goal of narrative therapy is to help people **re-author** their lives so as to define themselves in non-pathologising and non-problem-saturated ways. This is a collaborative practice, requiring of the therapist a consultative position. **Externalisation** is a technique used to help clients separate themselves from the

problem, viewing it without a sense of blame and failure. The objectification of the problem engages people in externalising conversations, which provide an account of the effect of the problem on their lives. **Unique outcomes** are sought in a search for exceptions to the problem, anything that does not fit with the dominant story.

Contradictions to the problem-saturated story are ever present, varied and many. Sometimes known as **sparkling events,** these exceptions shine or stand out in contrast to the problem story – they are elaborated upon using **landscape-of-action** and **landscape-of-consciousness** questions. The former type's of question address sequences of events, whereas the latter are concerned with the meaning of events. **Landscape-of-identity** questions involve preferences, values, personal qualities, skills and abilities, plans, motives and beliefs. E**xperience-of-experience** questions facilitate the re-authoring of lives and relationships – they generate reflection on a person's life and of how another person may experience them (West & Bubenzer, 2002:366-369; Morgan, 2000:52-60; Carr, 2000:138; Monk, *et al.* 1997:301-306; White, 1991:126-132).

Therapeutic solutions to problems are developed through the authoring of alternative stories, previously marginalised by the dominant narratives, and which fit the client's lived experience and open up possibilities for controlling their own lives. A therapeutic conversation or narrative interaction allows for a description of therapeutic change that transcends dominant themes, and comes to include new experiences, meanings and interactions that loosen the hold of the dominant discourse. Many possible directions can be explored in such a conversation, with none being more 'correct' (Carr, 2000:136; Morgan, 2000:3; Sluzki, 1992:219).

According to Monk *et al.* (1997:24), narrative counselling is not a formula or a recipe. It is a co-creative practice which views the client as having local, expert knowledge. Curiosity safeguards against counsellor 'expertise', opening space for new possibilities and directions. The narrative therapist uses basic relationship skills to enable the family

to tell their story. However, it is not assumed that symptoms serve a function for the family – rather problems are seen as oppressive (Gladding, 2002:255).

Sluzki (1992:220-221) sees each therapeutic encounter as idiosyncratic because the elements of process and content become interwoven with the contributions of all the participants. However, some common themes seem to emerge in narrative consultations - these are as follows: framing the encounter – often implicit and involving seating, opening exchanges and questions by the family and therapist; eliciting the dominant story; favouring alternative stories – exceptions that challenge the dominant story; enhancing the new story and validating it; anchoring the new stories through the use of rituals or tasks designed to confirm the new themes. Sluzki (1992:221) warns however, that this is not a design or blueprint for narrative consultation.

Sluzki (1992:218) poses a number of pertinent questions relating to how clients and therapists generate a number of plausible stories to account for a problem and its cause, and how change may be generated through so many different "…conversational avenues". He believes the answer lies in one common aspect – an alternative story is co-constructed by the therapist and family around the available cultural themes, thus the problem story loses its dominant hold and is redefined.

Narrative therapists link unique events to the past and extend the narrative into the future to form an alternative and preferred narrative that fits with the self. The use of outsider witnesses (significant members of the client's social network, others therapists, or even people unknown to the family) aims to consolidate change and witness the new narrative. White uses a reflecting team as a particular type of outsider witness group – the reflecting team is to be explored in Chapter 3. Hoffman (1995:xiii) distinguishes between the narrative approach to reflecting teams and that of Tom Andersen and Anderson and Goolishian. She states that the former is strongly therapist-driven and has an "…activist social frame". The latter is characterised by a "…purposeful

planlessness…" and is far less intentional. Hoffman believes that this divergence of philosophical background gives the two therapies a totally different feel.

New self-narratives may be documented using literary media, such as letters, certificates and declarations. Finally, clients are encouraged to give back to others suffering from similar oppressive narratives, through the sharing of their new narratives. All of these interventions serve to gain an alternative view of the client's life history and empower them to engage in behaviour consistent with their new narrative (Morgan, 2000:121; Goldenberg & Goldenberg, 1996:318).

Working with families from a narrative framework would appear to be sensitive to cultural differences, especially in the South African context where dominant discourses have tended to be Western-based, particularly concerning issues around family functioning and mental health. As with other postmodern approaches, comfort with a non-expert role would be a requirement for this type of intervention to feel authentic to the family therapist. However, as previously mentioned, power is implicit in all aspects of life, including human relationships, and hence, therapeutic relationships. It may be that the therapist him/herself is unaware of the insidiousness of dominant discourses that influence his/her beliefs and views relating to certain families or groups of people.
In an article critical of the postmodern 'fashion', Minuchin (1999:10) states that while he agrees with the importance of listening to and witnessing family narratives, he fails to see how this is sufficient or more significant than other forms of therapeutic intervention. Bertrando (2000:97-98) suggests that while stories are useful in understanding the experiences of the individual, the context of the family interaction is on a separate level – each family member's story is their personal experience. Narrative and postmodern thinking points to the political macro-context, but overlooks the micro-context in which the family is embedded.

Narrative therapy is social constructionist in its premises, using literary metaphors of stories and writing. The emphasis is on a collaborative relationship with families, used to co-create new narratives and thus, new realities.

Although not included in the above classification of family therapy approaches, the researcher feels compelled to include a discussion on postmodern feminist theory in order to enhance awareness of how dominant ideologies may influence the therapy session. Included too, is an overview of existential family therapy using the concepts of Viktor Frankl. This family therapy approach is directed toward facilitation of a family search for meaning. Without wishing to 'tamper' with the classification system of Carr (2000) used to structure the presentation of the theories discussed in this thesis, the researcher believes that the addition of these two approaches may enrich the exploration of family therapy theory based on belief systems.

2.4.2.7 A postmodern feminist approach

Feminist family therapy emerged from the growth of the women's movement and the growing belief that the subordinate role of women in patriarchal societies is perpetuated in traditional family therapy contexts, which normalise roles and behaviour according to beliefs about gender (Goldenberg & Goldenberg, 2000:46; 1996: 322).

According to Hare-Mustin (1994:21), postmodern feminists have focused on the way dominant discourses produce and sustain power against subordinate discourses of marginalised sectors of society, such as women, minorities, old and poor people. Discourse about women's participation in public and political life is systematically trivialised, subsumed or ignored. However, feminist efforts have brought some marginalised issues into public awareness, for example, the abuse of women and children. Hare-Mustin (1994:21) believes one way to assess the relative dominance or subordination of a discourse is to question what institutions and ways of being are supported by the discourse. She believes too, that both men and women participate in perpetuating dominant discourses, including those on gender. Through recurring, day-to-day practices and meanings, the discourses of gender differences and patriarchy are maintained and perpetuated in society.

Hare-Mustin (1994:24) goes on to describe how many discourses converge and interact to create familiar narratives, and that they co-exist to define what is expected of men and women by each other, and produce male/female identities. These identities become part of the individual's 'nature' and may constrict and compel their choices and behaviour. According to Goldenberg and Goldenberg (1996:320) and Kjos (2002:161), feminists view traditional approaches to family therapy as patriarchal and sexist, reflecting the context and times of their origins, but at the same time endorsing 'male' characteristics (e.g. logic, rationality, independence) while denigrating 'female' characteristics (e.g. nurturing, interdependence). These assumptions influence beliefs about desired family functioning and family roles. Feminism has challenged family therapy to address issues of power, patriarchy and inequality. While the researcher concurs with this challenge, awareness of one's own position regarding family roles and functioning is essential – the imposition of one's own values and beliefs upon a client family is both inappropriate and unethical. However, enabling the family to explore their own beliefs and the antecedents of these may give rise to new perspectives in keeping with the values of the client family.

Goldner and Luepnitz (in Goldenberg & Goldenberg, 1996:320) explore the unacknowledged "…sexual politics…" inherent in family therapy theory and practice, as well as the systemic view of participants in a system, which implies an equality of power that fails to take into account the larger socio-economic, political and cultural context of unequal status. Hare-Mustin (in Reimers & Treacher, 1995:192) articulates some differences between the "…alpha prejudice…" of some psychotherapies such as psychoanalysis which makes rigid distinctions between men and women, and the "…beta-prejudice…" of systemic theories which overlook gender differences and view all members of a system as similar and equal, and ignore the disadvantaged position of women and children.

According to Hare-Mustin (in Goldenberg & Goldenberg, 1996:320), ignoring differences between men and women in gender-role socialisation and in the power differential serves to reinforce the status quo and perpetuate the subjugation of women.

In the context of family therapy, if the therapist and family are unaware of subordinate discourses these will remain outside the room, and hence be unacknowledged and unexplored. If therapists see meaning as created in the therapeutic conversation but disregard the meanings associated with the social context of the individual's life, people come to be viewed as equal despite their position in the social hierarchy. Participants in therapy have differing authority in the family – inequalities influence the therapeutic conversation, i.e. who is allowed to speak, when and about what. Obviously this applies to the therapist too, if he/she is accorded greater authority.

The conversation in the session comes from the prevailing ideologies in the language community – it is this construction of reality that determines the therapeutic conversation. Conversation can be oppressive in what it excludes, and the therapeutic conversation can replicate limiting views of gender, race, age, etc. (Kjos, 2002:162; Hare-Mustin, 1994:23-33). When therapists are unaware of the pervasiveness of their views it is unlikely that they will open up alternatives for the family to consider. The development of self-reflexivity is a significant way to escape the subconscious ideologies that permeate our thinking and influence what we 'know'. Madigan (in Goldenberg & Goldenberg, 1996:321) states that it is essential that therapists be aware not only of their own values and beliefs, but remain sensitive to what values their actions reinforce in others.

Reimers and Treacher (1995:194) cite Walters, Carter, Papp and Silverstein who presented a number of guidelines to help feminist family therapists keep track of the issues that require exploration in therapy. These are:

- Identification of the gender message and social constructs that govern behaviour and sex roles.
- Recognition of the real limitations of female access to social and economic resources.
- An awareness of sexist thinking that constricts the choices of women to direct their own lives.

- Acknowledgement that women have been socialised to assume primary responsibility for family relationships.
- Recognition of the dilemmas and conflicts of childbearing and childrearing in society.
- Awareness of patterns that split the women in families as they seek to acquire power through relationships with men.
- Affirmation of values and behaviours characteristic of women, such as nurturing, connectedness, and emotionality.
- Recognition and support for possibilities for women outside of marriage and family.
- Recognition of the basic principle that no intervention is gender free and that every intervention will have a different meaning for each person.

Reimers and Treacher (1995:195) explore the work of Perelberg and Miller which contains examples of how gender issues can be used in therapy without clients feeling that issues crucial to the therapist are marginal to themselves. Reimers and Treacher (1995:195) further suggest that there is often a clash of perspectives between clients and therapists, which can undermine the success of therapy, but that there is also often a clash between male and female clients themselves. Expanding the therapeutic conversation to include wider gender issues may resolve such a difficulty. Again, self-awareness on the part of the therapist is essential – consideration of the need to push one's own views and agenda onto clients who may have a far narrower focus of concern is a dilemma which may need to be shared with the family. The researcher has witnessed a number of times, the seeming meaninglessness of gender issues for families, issues which the primary therapist or reflecting team raised at some point. Perhaps this illustrates the pervasiveness of patriarchal discourse.

According to Dallos and Urry (1999:177), feminist practitioners have contributed a major form of therapy which focuses on the individual, the relationship and the wider social context. These authors describe three central principles in the growth and development of feminist practice: a commitment to equality within therapy; a commitment to bringing the social context into therapy; a commitment to power

redistribution within society and equality between the sexes. To the researcher these principles are an important consideration regardless of whether one is practicing from a feminist perspective or any other.

Feminist family therapy forms the basis of gender-sensitive therapy, which emphasises egalitarian relationships with clients that promotes respect and collaboration, and a role that eschews manipulation and objective expertise. According to Goldenberg and Goldenberg (1996:319), feminist approaches differ from postmodernism in their belief that cultural and gender stereotypes dominate the belief systems of the family. Feminist and gender-sensitive therapies are distinguished in that the latter emphasise depth of understanding of both males and females, integrating gender-role stereotypical issues in the therapeutic encounter.

Postmodern thinking regards knowledge as partial and challenges the dominant discourses that marginalise alternative ways of thinking and behaving. A postmodern orientation proposes that all realities are constructions, some more influential than others. Feminist family therapy offers a viewpoint that encompasses recognition of women's subordination, the forces that maintain it, and a commitment to change that values equality between the sexes (Goldenberg & Goldenberg, 1996:321; Hoffman, 1990:7).

2.4.2.8 Existential family therapy

The work of Viktor Frankl, referred to as logotherapy, is directed toward helping people find meaning in their existence as human beings (Lantz, 1993:3). Based on his experiences as a prisoner in various concentration camps during World War II, Frankl developed his ideas about human behaviour which received wide acceptance. However, according to Lantz (1993:4) little has been published about family application of his ideas and concepts.

The basis of **logotherapy** is that meaning exists in all circumstances, life is unconditionally meaningful, and that the desire to find meaning in human existence is the primary motivation for most human and family behaviour. Life never loses its meaning, although meaning may be lost and regained (Durston, 2005a; Lantz, 1993:4). Failure to find meaning results in an **existential vacuum** which is filled in one of two ways – either by developing a sense of meaning, or by psychological or existential symptoms of depression, anxiety, despair, confusion and the experience of anomie (meaninglessness). The primary goal of logotherapy is to assist the client to find meaning in life, which fills the existential vacuum and limits the opportunity for the development of symptoms (Frankl in Lantz, 1993:4). According to Durston (2005a), logotherapy is not only a therapy but a lifestyle, in that it has a dual value, both for the period of crisis, and to serve as a strategy for a meaning filled life. It stems from a position of optimism, as we begin to understand that a life entire brings many unique opportunities.

Frankl (in Lantz, 1993:5; Durston, 2005a) discusses three aspects to meaning: the meaning of life; the will to meaning; and the freedom to will. The view that life has meaning differs from that of other existential thinkers who believe that life itself does not have meaning, but that human beings can decide to behave as if it does. Frankl on the other hand, argues that life itself has meaning, which is discovered in many ways that are unique to each individual. The spiritual part of the self can transcend biology, environment and the influence of past experiences.

Human beings face three existential problems, referred to as the **tragic triad.** These universal issues are: death, suffering, and guilt (Durston, 2005a; Lantz, 1993:5). The elements of the triad are catalysts that have the potential to evoke a meaningful response and reaction. According to Durston (2005a), society seldom allows people to find meaning in existential problems, inclining more towards pity, helplessness and "…disabling compassion…". Frankl (in Durston, 2005a) believed that the only way to find meaning in response to the existential problems is to act as if each day is our last,

and to view the transitory nature of life as something to be treasured, rather than something to be lost.

Logotherapy does not attempt to promise a life of pleasure and happiness, but rather is a lens to look at life in a new way (Durston, 2005a). Meaning in pain and loss is found by seeing that it requires a new attitude to living – one's attitude to life determines the meaning we invest in it. In the opinion of the researcher, this view resonates with a constructivist paradigm, whereby beliefs are constructed in the mind of the person and thus meaning is made.

According to Frankl (in Lantz, 1995:5-6; Durston, 2005a), there are three categories of values that can help people find meaning in life and to the existential problems in life. These are: creative values, experiential values, and attitudinal values. Creative values involve meaning in what we create through our work, commitment to a cause, and so on, and according to Durston (2005a) are aligned to the spiritual dimension of human beings. Experiential values are meanings found in our experience of nature, art and relationships. Attitudinal values develop is response to the meaning we find in tragic situations. Durston (2005a) speaks of a distinction between finding meaning **in** suffering, as opposed to insight derived from the wisdom of hindsight. The latter, he believes does not involve spiritual transcendence while in the midst of suffering.

Frankl (in Lantz, 1993:6) distinguishes between three dimensions of human existence: the physical, the psychosocial, and the spiritual. All three dimensions are relevant in understanding human beings, but the spiritual aspect frees us to think about the self and make changes to that self and to the environment. Tension is part of human existence and according to Frankl (in Lantz, 1993:7) equilibrium does not result in mental health but in a loss of meaning. Happiness is a by-product of a meaningful life, and to achieve happiness it is necessary to replace a search for this elusive state with a search for meaning. In other words, the search or goal is for the discovery of meaning rather than happiness, but happiness may be achieved through finding meaning in suffering and in life.

Lantz (1993:22) states that meaning and family interaction have a close and reciprocal relationship. The search for meaning can stimulate family interaction, which in turn stimulates increased awareness of meaning within the family. A lack of awareness of meaning or failure to discover, recognise and accept meaning, may result in dysfunctional interaction which further obscures awareness of family meanings.

Intervention with families is directed at the facilitation of the family's search for meaning. In direct form, intervention focuses on the family's ability to discover meaning in their shared history and family existence. This involves taking a **family life chronology** with emphasis on the meaning connections that family members may make about their unique history. Visual methods such as the family photo album may be helpful for family members to make connections. The **Socratic dialogue** involves facilitating communication in a way that helps the family to become more aware of their spiritual dimension, their strengths, values, hopes and achievements – it is the search for meaning in the ordinary events of life (Durston, 2005; Lantz, 1993:27). According to Lantz (1993:15), the Socratic dialogue is a technique used in both the Milan school and Franklian family intervention. The similarity lies in the use of questions designed to introduce new information into the family system – the difference with the Franklian approach is a focus on helping family members make meaning connections that stimulate awareness of the unconscious.

The indirect approach is used to help the family change dysfunctional interactional patterns that obscure the awareness of meaning. Compatible with the methods of Satir's communication methods and Minuchin's structural methods, Franklian family intervention involves reflection upon family patterns, reflection upon one's internal response to family patterns, and techniques such as de-reflection, paradoxical intention and provocative comments (Lantz, 1993:28-29; Durston, 2005b). Direct and open reflection by the family therapist about family patterns may develop awareness and insight into how family members inhibit the family's search for meaning. With regard to therapist reflection on internal responses to family patterns, Lantz (1993:33) cites Yalom who refers to "…existential countertransference…" which can be used to help

both therapist and family discover meaning. This form of reflection allows for the occurrence of involvement and meaning in the emotional life of the family, enabling the internal state of the therapist to become relevant in the therapeutic relationship, and facilitating the quest for growth of both the therapist and the family.

De-reflection entails the therapist helping the family to turn their attention to subjects other than the problem area. It challenges family patterns that are a reaction to hyper-reflection which inhibits the search for meaning (Lantz, 1993:35; Durston, 2005b). Hyper-reflection refers to excessive attention given to fears, symptoms or behaviour, which inhibits functioning. De-reflection redirects the family to other meaningful aspects of life. **Paradoxical intention** is designed to break vicious cycles that have developed in response to anxiety. In logotherapy, this technique is not used in a strategic or indirect way, but openly, to facilitate insight into cycles of anticipatory anxiety. According to Lantz (1993:35), used openly, paradoxical intention challenges reductionism and engages the family in accepting responsibility for change. **Provocative comments** may be useful to stimulate change in family interaction that helps the family to discover unique meanings as they occur in their interaction (Lantz, 1993:36). Such comments are only useful when they stem from a position of care, concern and respect, and can be destructive when used to express the therapist's hostility or to manipulate the family. In the opinion of the researcher, the use of such a technique requires considerable self-awareness and reflexivity on the part of the therapist.

Durston (2005b) stresses that meaning may not emerge immediately for the family, requiring a position of faith and acceptance of the process by the therapist. Meaning can at best be facilitated and described, but must "…unfold and be embraced by the conscience of the recipient". It is not the responsibility of the therapist to prescribe meaning.

Logotherapy in a family therapy context is an approach to helping the family in the search for meaning, based on the belief that this represents the most important human

activity. The researcher is of the opinion that this form of family therapy is one that would be very personal, requiring authenticity and meaningfulness on the part of the family therapist, and is more a way of being than an approach to be used to facilitate family change.

The strength of the approaches described above lies in the importance placed on a multitude of perspectives, with many creative techniques used to explore possibilities for change. A criticism of these views is the paradoxical view that the fundamental truth is that there is no truth, and the abandonment of systemic and cybernetic theory leaves little in the way of a framework for practice. Eron and Lund (1993:292) state that postmodern approaches have come under scrutiny for being "…soft on therapeutic direction and therapist responsibility" and vague with regard to what works to bring therapeutic change. Empirical evidence of effectiveness is still to be sought. As mentioned by many authors in chapter 1, as well as an opinion held by the researcher, an integration of the insights and practices from the various approaches may prove valuable, as no one approach has all the answers to therapeutic change.

The approaches to family therapy described in this section all focus predominantly on belief systems that form the bases of problematic interaction patterns. Constructivist, social constructionist, solution-focused and narrative theories all involve gaining new insight into problems in order to resolve them. They share common ground with cognitive-behavioural approaches to therapy insofar as they explore problem-maintaining belief systems. The original Milan school also aims at disrupting problem-maintaining interaction patterns and belief systems. Solution-focused and narrative approaches privilege the importance of exploring exceptions to problems, and of solutions over and above problems. Treatment tends to be brief, and personal growth is not a major focus. Feminist and gender-sensitive family therapy attempt to transcend the sex-role stereotypes that constrict peoples' functioning and impact on family relationships. Logotherapy is directed towards the facilitation of a family search for meaning.

In the next section, approaches that focus on historical, contextual and constitutional factors that predispose family members to the development of problems and maintain problem behaviour will be explored.

2.4.3 Theories that focus on Context

The previous sections focused on theories that are categorised in terms of their focus on behaviour patterns and belief systems. In this section the theories to be explored highlight the role of historical, contextual and constitutional factors in family dynamics. Approaches that fall into this category are: transgenerational family therapy; psychoanalytic family therapy; attachment based theories; experiential family therapy; and, psychoeducational family therapy.

2.4.3.1 Transgenerational family therapy

The basic premise of transgenerational family therapy is that the family-of-origin influences relationships and predisposes family members to develop current life problems in the family-of-procreation. Bowen and Boszormenyi-Nagy are key figures in the development of this approach, which is based on the belief that family problems are multigenerational phenomena resulting from patterns being replicated from one generation to the next (Carr, 2000:159; Hanna & Brown, 1999:15; Goldenberg & Goldenberg, 1996:165).

Bowen's theoretical contributions can be viewed as a bridge between psychodynamically orientated views that focus on self development, the significance of the past and intergenerational issues, and systems approaches that focus on current interaction patterns. The emphasis is on family anxiety and family emotional systems, extending over several generations. Family anxiety occurs under perceived threat, and families engage in recursive, emotionally problematic patterns of interaction. The degree of anxiety in the family determines the degree to which family members become differentiated (Geurin & Geurin, 2002:130; Carr, 2000:159).

According to Bowen, eight forces shape family functioning: differentiation of self; triangles; nuclear family emotional system; family projection process; emotional cutoff; multigenerational transmission process; sibling position; and societal regression (Gladding, 2002:128; Goldenberg & Goldenberg, 1996:169).

Highly anxious families are characterised by an **undifferentiated ego mass** – they are enmeshed or fused with extremely emotionally close relationships. In contrast, families with lower anxiety evidence a higher degree of differentiation and autonomy. Undifferentiated people deal with their families in one of two extremes: **cut-off**, whereby there is an attempt to keep distant and deal with family tension through having as little contact as possible; and **fusion or enmeshment**, which prevents a differentiated self from emerging. The degree to which differentiation of the self occurs reflects the extent to which each person is able to distinguish between the intellectual process and the feeling process being experienced. Thus a **differentiated self** can avoid his or her behaviour being unconsciously driven by emotion through a balance of feeling and cognition (Gladding, 2002:128; Goldenberg & Goldenberg, 1996:169-170).

Bowen sees the basic building block of the family's emotional system as the **triangle (**Gladding, 2002:130; Goldenberg & Goldenberg, 1996:173). When a certain level of anxiety is reached, a dyad (two person system) will involve a third person to dilute the anxiety – the triangle has a higher tolerance for dealing with stress. Generally the greater the degree of family fusion, the more intense are efforts to triangulate, with the least well differentiated person in the family particularly vulnerable to being drawn in to reduce the tension. However, triangulation does not always diffuse tension, and anxiety may even be heightened.

Transgenerational theory posits that people choose a partner with equivalent levels of differentiation to their own (Gladding, 2002:129; Goldenberg & Goldenberg, 1996:174). Two relatively undifferentiated partners i.e. a marital dyad, will probably recreate a family with the same characteristics and dynamics – the resultant **nuclear family emotional system** will be unstable and seek various ways to reduce anxiety.

Three possible symptomatic patterns may be the outcome of intense fusion between partners: physical or emotional dysfunction in a spouse, possibly becoming chronic, as an alternative to dealing with family conflict; overt, chronic marital discord with cycles of emotional distance and closeness of equal intensity, with anxiety being absorbed by the spouses; psychological impairment of a child who becomes the focal point of the family problem, and who absorbs family anxiety, becoming vulnerable to dysfunction. In addition, dysfunction in one spouse may take the form of **over-adequate** or **under-adequate reciprocity**, wherein one partner takes on most or all family responsibility while the other increasingly underfunctions (Goldenberg & Goldenberg, 1996:175).

The nuclear family emotional system is multigenerational with styles of relating learned in the family-of-origin and being passed along to offspring. According to Bowen (in Goldenberg & Goldenberg, 1996:175), the resolution to current problems lies in change in the individual's interactions with the families of origin, resulting in higher differentiation and less reactivity to emotional processes in the family.

The **family projection process** operates when parents, in their differential behaviour towards each child, focus on the most 'infantile' child (regardless of birth order) to project their own low level of differentiation onto. The child becomes triangulated into the parental relationship. The greater the level of parental undifferentiation the more likely they are to rely on the projection process to stabilise the system (Goldenberg & Goldenberg, 1996:176).

Children less involved in the projection process may have a greater ability to withstand fusion, to separate thinking and feeling – those more involved may try various strategies to insulate themselves from the family, either through geographical separation, the use of psychological barriers, or through **emotional cutoff**. This is viewed as a 'flight' from emotional ties rather than true 'emancipation'. Cutoffs tend to occur where there is a high level of emotional dependence and anxiety, with some members seeking distance in an act of self-preservation. According to Bowen (in Goldenberg & Goldenberg, 1996:178), it is imperative that therapists resolve their own

issues of differentiation to avoid being triangulated into conflicts with client families, and to ensure that their own unresolved issues are not played out in the family therapy arena.

Transgenerational family therapy views all generations as part of a continuous natural process. The concept of **multigenerational transmission process** is viewed as the outcome of the family's emotional system over several generations. The two concepts of selection of spouse with a similar level of differentiation and family projection process are relevant here.

Sibling position is viewed as significant by Bowen, who hypothesises that the more closely a marriage duplicates one's sibling position, the better will be its chance of success. Birth order frequently predicts certain roles and functions within the family emotional system, although often a person's functional position in the family system determines behaviour and expectations (Goldenberg & Goldenberg, 1996:178).

The final concept of Bowen's theory is **societal regression**, wherein society's emotional functioning mirrors the family with opposing forces of undifferentiation and individuation. An anxious social climate pushes society closer with concomitant erosion of differentiation and hence difficulty in the balance between emotion and intellect (Gladding, 2002:130; Goldenberg & Goldenberg, 1996:179).

Transgenerational family therapy occurs in stages with an initial assessment of the family's emotional system, past and present. The therapist must remain separate from the family's emotional system, not fusing with it or being triangulated into their conflict. Objectivity and neutrality, rather than emotional reactivity is the role to strive for. Family therapy is seen as a way of conceptualising a problem rather than a process requiring a certain number of family members to be present. Work with an individual family member towards a higher level of differentiation is not uncommon, based on the premise that if one person can increase their level of differentiation the functioning of the whole family may improve.

Evaluation begins with a history of the problem, emotional functioning, anxiety levels at different stages of the life cycle, and degree of stress. The genogram is a graphic portrayal of multigenerational family patterns and is a crucial technique in transgenerational family therapy, often providing families with their first inkling of intergenerational family patterns. Two goals are the focus of therapy: a reduction of anxiety and relief from symptoms; and an increase in each participant's level of differentiation. Bowen himself often worked with the parents, even when the identified patient was the child, based on the premise that the problem lies with them and their level of differentiation. Family members talk to the therapist rather than directly to one another – confrontation is avoided to reduce the emotional reactivity between them. The paradox of this form of family therapy is that by **not** focusing on relationships but on autonomy and differentiation, family relationships are enhanced (Carr, 2000:159-161; Thompson & Rudolph, 2000:314-319; Worden, 1999:17-18; Goldenberg & Goldenberg, 1996:168-184).

According to Gladding (2002:133), the differentiation of the therapist from his/her own family-of-origin is crucial in transgenerational family therapy. Objectivity and neutrality are seen as significant characteristics for the therapist to display - the therapeutic focus is systemic and the practice cognitive in nature. From the experience of the researcher, objectivity and neutrality are a challenge in the complex arena that is family therapy. Family therapy seems to evoke a multitude of opinions, beliefs, ideas and resonances for practitioners. Perhaps if one is working with an individual member rather than the whole family such neutrality and objectivity may be more achievable. In addition, the researcher wonders whether objectivity and neutrality can coincide with authenticity, echoing Bowen's own sentiments that this would require a high degree of self-differentiation from the therapist.

Criticism of the approach centres on it being focused on the past rather than on the present circumstances of the family; promoting insight before action; and the view that the number of people who can benefit from this approach may be limited (Gladding, 2002:135).

In conclusion, transgenerational family therapy is based on the assumption that relationships and events from the family-of-origin predispose people to developing problems in their current lives. Family problems are viewed as multigenerational phenomena where patterns of interaction are repeated from one generation to the next.

2.4.3.2 Psychoanalytic family therapy

According to Goldenberg and Goldenberg (1996:110), psychoanalytic theory, despite its seeming emphasis on the individual, is grounded in the interaction within the family. Many of the pioneers of family therapy, such as Ackerman, Bowen, Minuchin and Boszormenyi-Nagy were psychoanalytically trained, and a focus on systemic thinking has not necessarily replaced the idea of individual pathology being linked to childhood developmental conflict. The classical psychoanalytic view of Freud has been succeeded by a briefer, more flexible procedure and methodology. A more balanced view that recognises the family as a system, as well as the unique experiences of the individual, has resulted in frameworks that attempt to integrate systemic and psychoanalytic concepts. One such framework is object-relations theory, developed from Ronald Fairburn's theory and the work of Klein, Winnicott, Dicks and later, Scharff (Gladding, 2002:119; Carr, 2000:163; Goldenberg & Goldenberg, 1996:111).

Object-relations theory evolved from the study of early mother-child relationships with attention drawn to the persistent impact of those experiences on later adult functioning. This is in contrast to Freud's intra-psychic, drive-orientated theory which suggests that the infant's struggle is to resolve sexual and aggressive impulses aimed at acquiring gratification from a parent (Scharff & Scharff, 2002:253; Goldenberg & Goldenberg, 1996:118). The focus of object-relations theory is on internalised 'objects' that are mental images of other people built up from experiences and expectations. The belief is that we relate to people based on the expectations formed by early experiences, and which unconsciously influence our lives in powerful ways. The infant uses the defence mechanism of **splitting** - this involves viewing the mother as two separate people, the good object who satisfies their needs, and the bad object who frustrates them. Splitting

allows the child to protect the good object from the threat of annihilation by directing anger at the bad object.

According to object-relations marital and family theory, romantic partners use **projective identification** to project onto each other an image of what they unconsciously cannot accept in themselves, rather than responding to the reality of who their partner is – the partner is manipulated to behave in accordance with this projection. As the relationship matures and exceptions to these projections become apparent, the projection process is gradually replaced with more accurate perceptions. In problematic relationships partners either conform completely to the demands of their partner's projections, or do not conform sufficiently. Either option leads to disappointment and conflict but the couple remain bound together because the projection process allows them to view the 'self' as all good and the partner as all bad.

Symptomatic behaviour in a child may be a means of deflecting attention from marital conflict (Goldenberg & Goldenberg, 1996:122). Identification of this role as 'patient' detriangulates the child from the marital dyad and the therapist may continue to work with the couple to maintain the integrity of the marital unit. Framo (in Goldenberg & Goldenberg, 2000:129; 1996:123) argues that intrapsychic conflicts stemming from the family-of-origin are repeated, defended against, lived or mastered in relationship to one's partner, children and other significant people. This view is reiterated in Carr (2000:164) wherein it is stated that unconscious intrapsychic problems impact on the marital relationship, as well as being passed along to children who will perpetuate similar problems in their own marriage. Family-of-origin therapy consists of involving each partner, individually in sessions with the family-of-origin in order to work out past or current problems with a therapist. The goal is to explore issues impacting on the current family and to provide a corrective experience with parents and siblings. It may serve to have a restorative function, reconnecting family members and healing rifts.

According to Goldenberg and Goldenberg (2000:132; 1996:125), the family therapy approach most faithful to object-relations theory comes from the collaboration of David

Scharff and Jill Scharff. Unlike individual psychoanalysis, the focus is on the family as a system of relationships that function to support or obstruct the progress of the family and its separate members, through the stages of the life cycle. The family is viewed as an interpersonal, cybernetic system that has difficulty negotiating a developmental transition, and family problems represent manifestations of family system disturbance. Where this view differs from other family therapy approaches is the belief that change in the individual can induce change in the family (Goldenberg & Goldenberg, 1996:126). This view is shared by Bowen who suggests that the achievement of a higher level of differentiation of self on the part of one member from the family-of-origin, may facilitate change in the family.

Interpretation by the therapist, in an attempt to provide insight, is essential, and the therapist adopts a neutral stance, based on the belief that he/she can move outside the family system and observe what is happening in the family and in the self of the therapist. A nurturing therapeutic climate is created to allow family members to reclaim lost parts of the family and of the individual self. Assessment involves exploring the family's shared object relations, the stage of psychosexual development, and the use of various defence mechanisms. Intervention aims at working through interaction patterns and unconscious defensive projective identifications. Treatment is viewed as successful if increased insight or self-understanding is enhanced, with improved capacity to manage developmental stress (Goldenberg & Goldenberg, 1996:127). Gladding (2002:124) believes that psychodynamically-based approaches emphasise linear, cause-and-effect interactions, in contrast to most family therapies, are expensive in terms of time and financial commitments, and require above-average intellectual ability from participants.

The psychodynamic tradition today is largely based on object-relations theory which focuses on the infant's primary need for attachment to a caring person and the analysis of those internalised psychic representations or objects that continue to be a need for satisfaction in adult relationships.

2.4.3.3 Attachment-based therapies

John Bowlby was the originator of attachment theory, which attempts to explain the development of significant family relationships and relationship problems from the early bonds between children and their caregivers (Carr, 2000:165; Donley, 1993:4).

Bowlby suggests that attachment behaviour, essential for survival of the species, begins around 6 months of age and lasts until approximately 3 years of age. When a child is faced with danger, he or she will seek closeness with the primary caregiver, before returning to exploring the environment once comforted. The pattern is repeated each time the child perceives a threat and over time he or she will build an internal working model of attachment relationships based on the way in which these episodes are managed by the caregiver. This internal working model is a cognitive map or template based on early attachment experiences, and which presents itself in adult intimate relationships. Four categories of parent-child attachment are identified, the styles of which show continuity over the individual lifecycle, and hence have implications for significant adult relationships (Carr, 2000:166-167). The four attachment styles are:

- **Secure attachment:**

Securely attached children and marital partners react to the parents or partners as if they are a secure base from which to explore the world. Parents and partners in such relationships are in tune and responsive to the child's or partner's needs. Family relationships are adaptable and flexibly connected, and family members are autonomous. The styles described below are all based on insecure attachment.

- **Anxious attachment:**

The anxiously attached child seeks contact with the caregiver following separation but is unable to derive comfort from it – he or she may cling, cry or throw tantrums. Marital partners of this style tend to be overly close but dissatisfied. Family relationships characterised by anxious attachment tend to be enmeshed with blurred boundaries.

- **Avoidant attachment:**

The avoidantly attached child may avoid contact with the caregiver following separation. Marital partners with avoidant attachment tend to be distant and dissatisfied, while families tend to be disengaged with impermeable, rigid boundaries.

- **Disorganised attachment:**

Children with a disorganised attachment style show characteristics of both anxious and avoidant patterns following separation. This style of attachment is correlated with child abuse, child neglect and early parental absence, loss or bereavement. Marital and family relationships are characterised by approach-avoidance conflict, disorientation and alternate clinging and sulking.

Emotionally-focused couple's therapy, the work of Greenberg and Johnson, assumes that marital conflict arises when partners are unable to meet each others attachment needs for security, safety and satisfaction. Initially this failure to meet each other's attachment needs arouses emotional responses of disappointment, fear, sadness and vulnerability which remain unexpressed. This results in frustration which leads to secondary emotional responses such as anger, hostility, or the desire to induce guilt or get revenge. Behaviour becomes focused on an attack-withdrawal (or pursuer-distancer) pattern which may evolve into attack-attack or withdraw-withdraw patterns. These attempts to elicit caregiving from the partner are based on insecure attachment styles which elicit behaviour that ensures that their attachment needs will inevitably be frustrated. Therapy aims to enable the couples to find ways to meet each other's attachment needs and develop a secure attachment style (Carr, 2000:168).

According to Donley (1993:10), in order to understand the complexity of attachment, one must focus on the 'emotional field' of the entire family. The emotional field refers to the complex emotional stimuli that exist among family members who are in a dynamic process of interaction. Donley believes that the emotional field of the nuclear family emerges from the emotional field of the parents. Included are relationships with the family-of-origin, this view thus sharing a theoretical similarity with

transgenerational family theory. The balance between individuality and togetherness is reflected not only in the couples' relationship but also in the overall emotional involvement with the children.

The work of John Byng-Hall, who trained with Bowlby, proposes a model of family therapy based on attachment theory and script theory. He suggests that predictable rules, roles and routines governing family life are guided by family scripts, learned in repeated interactions in the family-of-origin. These interactions occur in a context, entail a specific plot and involve roles and motives for participants. **Scripts** may be **replicative** (repeating interactions from the family-of-origin in the current family); **corrective** (scenarios which are played out opposite from the way they occurred in similar contexts in the family-of-origin); and **improvised** (scenarios are created that differ significantly from those which occurred in similar contexts in the family-of-origin) (Carr, 2000:169).

According to this theory, family scripts may be inadequate and improvised scripts may be required to manage family lifecycle transitions, stress and so on. A secure family base, allowing for exploration and experimentation is necessary for the effective creation of an improvised script. The role of the therapist is to provide a secure base and containment for family affect so that a new script can be devised. Techniques from structural family therapy may be used to help families explore rules, roles, etc. and explore new possibilities. At the same time this may evoke anxiety in the family and the therapist must avoid being recruited into the family roles, perhaps using live supervision to track the process and reflections on their experience of attempts at recruitment. This approach explores the impact of historical family scripts and attachment styles that impact on family functioning. The aim is the development of secure family attachment that may enhance improvised scripts and thus problem-solving – a further goal may be increased awareness of family interaction patterns (Carr, 2000:170).

As with the contextual theories discussed above, it would appear that a family therapy practitioner favouring this type of approach would need to be comfortable with the position of expert in the therapeutic encounter, as well as have a firm belief in his/her ability to remain outside of the system as a neutral observer.

Attachment based theories focus on the impact of early attachment to a caregiver as a feature of marital and family dysfunction. A secure attachment style enhances adaptive family functioning, while insecure attachment styles predispose families and couples to developing problematic belief systems and behaviour patterns.

2.4.3.4 Experiential family therapy

The focus of experiential family therapy is on highlighting the role of experiential obstacles to personal growth that predispose people to developing problems and problem-maintaining behaviour patterns. Of significance to this approach is affect, or emotion. Experiential family therapy draws from the person-centred approach of Carl Rogers, Gestalt therapy (Fritz Perls), and psychodrama (Moreno), as well as ideas from personal growth movements. Experience, intuition, process, growth, spontaneity and the here-and-now are concepts relevant to experiential family therapists. Therapeutic change occurs in growth experience and not merely in intellectual reflection and insight into the origin of problems. Therapeutic interventions are tailored to the specific and unique needs of the family and psychotherapy must be an interpersonal encounter between therapist and client that is genuine, the aim being to enhance sensitivity, the expression of feelings and personal authenticity. Significant figures in experiential family therapy include Virginia Satir and Carl Whittaker, to be discussed in more depth below (Gladding, 2002:146; Carr, 2000:170; Hanna & Brown, 1999:18; Goldenberg & Goldenberg, 1996:135).

A humanistic orientation guides experiential family therapy, the basic premise of which is the drive to self-actualisation, given that the social and familial environment is adequate. Within this framework, it is presumed that the healthy family is able to cope

with stress, acknowledge personal differences and differing needs, communicate clearly and resolve problems. Problems occur when family members are subjected to rigid, punitive rules, roles and routines that result in a distortion or denial of their experiences in order to be accepted by the family. Such denied or distorted experiences lead to an incongruity between the self and experience. Incongruity within the individual, a result of the prohibitions and injunctions internalised from the family-of-origin, is played out in the marital and parental relationships. Denial of strong emotion such as anger may be projected onto one child who becomes scapegoated and labelled 'mad, sad or bad' (Carr, 2000:171). Gladding (2002:149) describes the underlying premise of the experiential approach as a lack of awareness of emotion, or suppression of emotion, thus creating a climate of **emotional deadness**.

According to Satir (in Thompson & Rudolph, 2000:339), all families may be divided into two types: nurturing and troubled. Nurturing families assist members to develop self-worth, whereas troubled families diminish these feelings. In addition, the nurturing family is characterised by a number of attributes: effective listening; a lack of fear; friendliness; openness; affection; real communication about feelings; freedom to express feelings; parents being able to own both good and bad judgment; parents being able to correct children in ways that do not devalue the child. Troubled families on the other hand, would tend to display attributes opposite to those of the nurturing families.

The experiential family therapist believes that unresolved issues from childhood must be resolved in adulthood if self-actualisation is to occur. Such unresolved issues in this context refer to feelings about relationships with parents or significant others, or about disowned aspects of the self. Therapy focuses on the growth of each family member rather than on the resolution of specific problems. Personal growth entails increased self-awareness, self-esteem, self-responsibility and self-actualisation. In this process of realising one's full human potential, communication becomes more congruent, awareness of experiences is heightened, responsibility is assumed for one's actions, and the disowned parts of the self become integrated (Gladding, 2002:161; Carr, 2000: 171-172).

Intervention is active, spontaneous, idiosyncratic and often self-disclosing, making use of various 'evocative' techniques to facilitate awareness of feelings and inner experiences. The role of the experiential family therapist is that of facilitator, helping families discover their strengths and promoting better communication (Gladding, 2002:159).

The therapist strives to be real and **authentic**, rather than a blank screen or wearing a therapeutic mask – in this process of encounter with clients, therapists may have to deal with their own vulnerabilities (Goldenberg & Goldenberg, 1996:136). Carr (2000:172) too, discusses the necessity for an authentic "…therapeutic alliance…" and stresses the point that the more authentic the therapeutic relationship between client and therapist, the more effective the therapy. The conditions for facilitation of the therapeutic process are: **warmth; unconditional positive regard; congruence; and non-judgment**. A further factor necessary for facilitation of change is the degree to which the therapist can help clients to experience deeply, a wide range of emotional responses to significant experiences of their lives within the therapy session.

Because of their importance in the field of family therapy, the work of Carl Whitaker and Virginia Satir deserve particular mention (Gladding, 2002:146-148; Carr, 2000:173-176; Thompson & Rudolph, 2000:340-346; Goldenberg & Goldenberg, 1996:136-162). The work of these two charismatic family therapists is highlighted as follows:

- **Carl Whitaker:**

According to Carr (2000:137) and Snow (2002:298), Whitaker epitomises the experiential family therapist – unconventional, colourful and provocative, an advocate for the 'active' therapist who strives for growth and integration (maturity) rather than merely offering insight to promote adjustment to society. Whitaker held strong views on the process of **scapegoating** in the development of family problems. When a person becomes symptomatic, he or she has been scapegoated, by having the negative feelings within the family displaced onto him or her. Whitaker assumed that families will resist

engaging in family therapy, as this would entail accepting that the symptom-bearer is indicative of wider family difficulties. In addition, family therapy opens up the possibility that denied family difficulties would have to be explored. Scapegoating also implies that the family, if they did attend therapy, would avoid taking responsibility for resolving problems and look to the therapist to solve problems for them.

Within this framework, Whitaker suggested that for family therapy to be effective, two confrontative interventions are essential in the first stage of therapy, namely the **battle for structure** and the **battle for initiative**. With the former, the therapist offers a therapeutic contract which specifies that all sessions must be attended by all family members. In the battle for initiative, the therapist places the primary responsibility for content, process and pacing of therapy sessions on the family. These two interventions maximise the opportunity for confronting and undoing the scapegoating process, and thus help the family resolve denied difficulties.

Once therapy was underway, Whitaker would concentrate on **being with** the family rather than on specific techniques. To Whitaker, being with the family involved the intuitive use of self-disclosure and 'craziness', both being creative, non-rational, lateral-thinking yet non-directive in the process. A context is created within which the family can experience new ways of being, be more comfortable in the expression of impulses and fantasies, thus opening up new possibilities for them. Whitaker often worked with a co-therapist, in order to maximise his being 'crazy' while the co-therapist took on a more rational role in the team.

Valuing openness and spontaneity in interaction with the family above theoretical formulations, Whitaker often borrowed concepts from other approaches (e.g. enmeshment, triangulation, life cycle transitions) to describe what he believed may be blocks to family growth and role flexibility. Whitaker described his idiosyncratic therapeutic style as the "psychotherapy of the absurd" and views his intervention as being controlled by his 'unconscious', not always knowing why he says or does something – however, his interventions consistently challenge the meanings people give

to events, allowing them to take risks and explore alternative ways of being together as a family. One may speculate that the creativity and idiosyncrasy of this way of being in a therapeutic encounter has a postmodern flavour, allowing for differences of perspective and meaning to occur, and thus to create the possibility of change.

Of great significance to Whitaker is the person of the therapist. He stressed the need to 'stay alive' as a human being and as a therapist, insisting that the therapist must uncover his/her own belief system and symbolic world, and then use the self (rather than specific techniques) to grow and help families to do the same. Whitaker urged therapists to take care of their own needs in the process of caring for others, to abandon rigid rules that inhibit growth, and to remain flexible and available to new experiences without knowing what the 'right' answer is.

- **Virginia Satir:**

Satir, a social worker described as inspirational and charismatic, was one of the founders of the family therapy movement. Described as a prolific writer, Satir published the first groundbreaking text of conjoint family therapy. In her later writings, Satir identified her approach as a Human Validation Process Model, wherein therapist and family join forces to facilitate health-promoting processes in the family (McLendon & Davis, 2002:170).

Satir (in Goldenberg & Goldenberg, 2000:153; 1996:154) believed that all humans strive for growth and development, that people have the resources to fulfil their potential, albeit that these resources may become blocked or distorted. The family is viewed as a balanced system – symptoms in one family member indicate a blockage to growth and have a homeostatic function of keeping the family in balance. The rules that govern a family are related to how the partners achieve and maintain their own self-esteem, which in turn creates the context in which children develop their self-esteem.

Four problematic styles of communicating may evolve in families where affect is denied or distorted. **Blaming** is a communication style used to avoid taking

responsibility for resolving conflict – it is characterised by complaining, bullying, judging and comparing, with no ownership of ones' role in the conflict. **Placating** is a communication style used to defuse, rather than resolve conflict – conflict is denied, differences are covered up and attempts to please and pacify are characteristic. **Distracting**, also referred to as being irrelevant is characterised by avoiding conflict by changing the subject, pretending to misunderstand, feigning unawareness of what is happening. **Computing** or being super-reasonable involves avoiding emotional involvement with others, characterised by an overly intellectual and logical approach, lecturing, taking the higher moral ground (Gladding, 2002:151; Carr, 2000:174; Goldenberg & Goldenberg, 2000:156; 1996:157). According to Satir, the only congruent communication style is **levelling**, characterised by emotional engagement, congruence between verbal and non-verbal messages, directness and authenticity, all of which foster personal growth. According to Satir (in Goldenberg & Goldenberg, 1996:157), the problematic communication styles are essentially poses that keep distressed people from exposing their true feelings because they lack the self-esteem to be themselves.

Satir's therapy involved subtly modelling and coaching family members in levelling with each other - she taught people congruent ways of communicating to enhance their ability to get in touch with and accept their feelings. In this way she helped people build their self-worth, opening up possibilities for choice and change in their relationships.

In addition to enhancing verbal communication, Satir used touch- and movement-based techniques. Family **sculpting** involves positioning each family member spatially, so that their positions and postures represent their inner experience of being in the family, and conveys their psychological representation of family relationships. Future-orientated family sculpts can be used to help family members to envisage how they would like things to be, and to compare with how they experience the family at present (Gladding, 2002: 152; Carr, 2000:175.)

Family **reconstruction** is a technique which allows the family to reconstruct and re-experience significant events from earlier stages of the family life cycle. The purpose of the technique is to help family members discover dysfunctional patterns in their lives stemming from their family-of-origin. Blending elements of psychodrama, Gestalt therapy, guided fantasy and role-play, the aim is to re-enact multi-generational events that keep people trapped in entrenched perceptions, feelings and beliefs. This technique may activate strong emotion that may have been beneath the level of awareness – experiencing and owning these feelings may promote personal growth (Gladding, 2002:154; Carr, 2000:175; Goldenberg & Goldenberg, 1996:162). Related to this technique is the **parts party** – family members are directed to role-play different parts of their personality and to interact in a way that metaphorically reflects the way these different aspects of the self coexist within the person. Again, strong emotion may be evoked, the ownership of which may promote growth.

In some cases, Satir would initiate treatment by compiling a **family life chronology** to understand the history of the family's development. This goes beyond merely gathering historical information – it is an attempt to explore family patterns and relationships. The **wheel or circle of influence** aims to explore those individuals who have been important in the family (Gladding, 2002:155: Goldenberg & Goldenberg, 1996:162).

Criticism of the approach focuses on its dependence on the charisma, intuition and sensitivity of the therapist, as typified by Satir and Whitaker, which are impossible to emulate. The researcher speculates that any attempt at emulation may be undesirable and possibly inauthentic, given the significance of the fit between a chosen approach and the self. While the experiential approach may typify the charismatic and idiosyncratic styles of Whitaker and Satir, it does not suggest that no other family therapist would have the necessary qualities to facilitate the growth of family members. Other criticism centres on the focus of therapy being on present issues which may inhibit the exploration of historical patterns or events. According to Gladding (2002:163), while personal growth may be an admirable goal, it may be insufficient to alter family dysfunction.

Experiential family therapy emphasises the therapeutic encounter as fundamental in the human drive towards growth and the achievement of potential. Major practitioners included Whitaker and Satir – their humanistically orientated practices were characteristically unique, charismatic and often unconventional in the quest for increased self-awareness, self-responsibility, self-esteem and self-actualisation.

2.4.3.5 Multisystemic family therapy

The central premise of multisystemic family therapy is that family members engage in problem-maintaining interactions within the family because of concurrent involvement in certain types of social systems beyond that of the family. Multisystemic family therapy has shown effectiveness with multi-problem families where delinquency and drug abuse have been identified issues (Carr, 2000:176).

This form of therapy is grounded in the theory of Bronfenbrenner, wherein the social ecology influences people's behaviour. With the individual at the centre, influences occur first within the family system, the peer group, neighbourhood, school/work environment, health/social/other services and, finally the wider community.

Assessment involves evaluating the identified problems, the factors that contribute to and maintain them, as well as potential resources within the multisystemic context. Interviews may be conducted with the child, family, school or work, as well as with other professionals and agencies.

Intervention is focused on the present and on taking action. Specific problems are identified during assessment and targeted for intervention – such intervention must fit with the social ecology and stage of development of the person. Other individually focused approaches may be used concurrently, such as cognitive-behavioural therapy to improve self-esteem or lessen anxiety. Behavioural, structural and strategic family therapy interventions are used to enhance family functioning. Multiple agencies may be consulted in order to enhance cooperation and problem management.

The implementation of this form of family therapy is delivered by small teams of professionals who are closely supervised. Sessions may be home-based with crisis intervention services offered. The aim of multisystemic family therapy is to modify contextual factors in the wider social systems around the family (Carr, 2000:176-177).

A similar form of family therapy is Multiple Impact Therapy, described in Goldenberg and Goldenberg (2000:101; 1996:292-294). This involves the use of a team of mental health professionals over an intensive two day period – the team works with the family in crises to develop a therapeutic plan to intervene in mobilising resources, using various interventions to assist the family and to change problematic systemic interactions, and make relevant recommendations for dealing with day-to-day problems.

It appears that multisystemic family therapy is an eclectic model of intervention, suggesting the necessity of an in-depth understanding of different approaches to family therapy, as well as knowledge of relevant resources available in the community. In the South African context, this model would be more suited to the urban environment, since resources in rural areas remain scarce. However, aspects such as home-based intervention may be valuable in communities where transport is an issue for the family members, assuming of course that the family therapy practitioner has transport.

Thus, multisystemic family therapy aims to modify predisposing contextual factor's in the wider social systems.

2.4.3.6 Psychoeducational family therapy

Certain empirical research indicates that some individuals are genetically or constitutionally predisposed towards the development of psychological problems (e.g. schizophrenia, mood disorders). The course of these disorders may be influenced by stress and the degree of available support in the psychosocial environment. Psychoeducational family therapy intervenes to assist families to understand the factors contributing to the etiology and course of these illnesses, and provides family members

with the skills to promote a supportive home environment. Thus, instead of searching for the source of the illness, symptoms, causes etc., skills are taught in order to overcome obstacles to family functioning. According to Goldenberg and Goldenberg (1996:323), the psychoeducational approach has more in common with the medical model than with systemic thinking. Lefley (1996:132) concurs, stating that this type of intervention is better suited to family treatment in dealing with chronic mental illness.

This approach aims to make families aware of the psychological difficulties of the identified individual, providing a theoretical framework and plan of action to assist with problem-solving, communication and the management of medication, as well as providing social support through resource networks and support groups. A diathesis-stress model is used to explain psychological disorders as being the result of a genetic predisposition in conjunction with excessive stress in the absence of mitigating protective factors (e.g. medication, social support, coping skills).

The psychoeducation format may take the form of working with individual families or with multiple families simultaneously. Corcoran and Phillips (2000:432) identify the goals of psychoeducation with multi-family groups as being:

- To provide information about the nature and course of the illness to the family.
- To teach families about medication and its side effects.
- To reduce stress.
- To provide information on treatment options and community resources.

Single family interventions may also provide these psychoeducational components, often in conjunction with other forms of treatment such as behavioural or systemic family therapy. The aim is to provide a stabilising environment in which families feel that they are not being blamed or criticised, and where they can learn coping skills for maintenance and prevention of relapse (Goldenberg & Goldenberg, 1996:327). According to Lefley (1996:130), family therapy may covertly ‘blame’ the family for the illness of their relative, and many families may not be helped by traditional approaches

that are based on systemic thinking, which conflicts with the reality of mental illness as a chronic source of stress to the family.

A distinction is made between controllable and uncontrollable stress – for the former, problem-focused strategies are appropriate, for example, planning, instrumental help, problem-solving. Regarding the latter, emotion-focused strategies such as relaxation, reframing and social support are used. This enables the family to have various strategies at their disposal to be used in different circumstances (Carr, 2000:177-179).

Pscyhoeducational approaches equip family members with the skills to manage physiological or constitutional vulnerabilities that predispose individuals to developing psychological problems. The researcher is of the opinion that this form of intervention is more suited to a multi-disciplinary setting, where different professionals are able to coordinate their interventions for the benefit of the family.

2.4.3.7 Multi-cultural considerations in family therapy

According to Lee (2003:393), culturally sensitive practice in a diverse society is extremely complex. Lee suggests that minority groups are under-served by most mental health services, and that issues of power, equal access to services, and language and cultural barriers have been obstacles to obtaining help for many families. Gladding (2002:319) concurs with this view, adding that cultural minorities are also affected by the same social pressures that impact on other families. The researcher believes these aspects are only too apparent when related to the South African context. However, in South Africa we have a paradoxical situation, whereby services have historically been aimed at a dominant minority, with few resources spared for the majority. Currently, a more equitable provision of resources is hampered by various factors, including the economic climate.

Gladding (2002:317) defines culture as the "…customary beliefs, social forms, and material traits of a racial, religious, or social group". It incorporates the behaviours and

traditions and the "…collective realities of a group of people" (Lee in Gladding, 2002:317). Culture involves both conscious and unconscious aspects and practices. According to Worden (1999:44), the broader cultural context is the family's ethnic heritage, a heritage that is steeped in the norms and values transmitted over generations that provided the family with an identity and expectations regarding behaviour. It is through culture that we understand and organise our experiences of the world, while ethnicity provides a common ancestry, historical continuity and sense of belonging.

Thompson and Rudolph (2000:349) describe the fairly recent entry of families of many different cultures into the family therapy arena. Although these authors are exploring this in the context of the USA, this aspect has as much relevance for South Africa. These authors suggest that counsellors need to familiarise themselves with the customs, styles, norms, communication patterns and standards of behaviour of diverse groups. This requires openness to the uniqueness of every family and how the family responds to distress in relation to its culture. Current counselling practices reflect Western, white middle-class values that may be antithetical to the belief systems of different ethnic and racial groups (Lyddon, 2001:582). Gladding (2002:319) concurs, stating that family therapists are typically middle-class, socialised in terms of mainstream values regardless of their ethnic origin. These values may be at odds with the values of some families they encounter, again highlighting the importance of self-awareness and reflexivity. Gladding (2002:319) refers to the "…culturally encapsulated…" counsellor who is insensitive to difference, makes assumptions about groups of people, and may even display overt or covert prejudice that negatively impacts on the therapeutic process.

According to Worden (1999:45), ethnicity exerts a powerful influence on the individuals in a family, and on the nuclear family from the extended family. Observations of black families in therapy show that traditional sources of help have been the extended family, church leaders and close friends. The legacy of racism in the USA has meant that black families have been reluctant to enter therapy. In the opinion of the researcher, this is equally valid for the South African context, albeit one that has

changed significantly over the past few years and evidenced by the fact that more families of different cultures are entering into counselling at the organisation under exploration.

Reiss (in Worden, 1999:45) speaks of the family's capacity to construct its own view of reality and refers to the 'family paradigm' which guides the behaviour of family members and serves as a map to make sense of their world. This concept of the family paradigm is similar to the social constructionist view of family narratives, with shared interpretations of reality which are reinforced by ethnicity.

Lee (2003:385) sees a major challenge facing clinical social work practice in the changing demographics of society. People in diverse ethnic and racial groups are demanding to speak for themselves and seek legitimacy for their groups. The challenge of working with different cultures lies in how to provide intervention that fits the cultural context. Lee (2003:386) believes that despite certain universal aspects, human behaviour can only be understood in the specific cultural context.

Lee (2003:386-387) suggests a number of characteristics required for cross-cultural practice. They are:

- Incorporating clients' multiple worldviews – practitioners should refrain from making assumptions based on any specific theory with regard to the family, their functioning, what the goals and solutions should be. Treatment should be adapted to suit the specific needs of the family.
- Empowerment-based practice and a collaborative approach – this involves participative relationships with families, and mutual problem-solving and decision-making. Respect for client self-determination and the identification and building of client strengths are important aspects of practice.
- Utilising cultural strengths and resources - a strengths perspective is based on the assumption that all people and environments have resources and abilities that are either underused or not used at all, and that people are capable of continual growth

and change. Curiosity and appreciation of the cultural strengths of clients, and assisting clients to identify, expand and use these resources typify a solution-focused approach to helping.

Gladding (2002:332) states that for family therapists to be competent in their work with culturally diverse families, they need to examine their own values and biases. This exploration is both emotional and intellectual, and requires: awareness of own cultural heritage and respect with regard to differences; comfort with cultural differences; sensitivity to cultural circumstances that may dictate referral; knowledge of own attitudes, beliefs and feelings with regard to cultural differences.

According to Holland and Kilpatrick (1993:302), social workers, or for that matter any practitioner of family therapy, can develop greater sensitivity to the themes and issues arising in practice with clients from different cultures, through reflective examination of the stories families share about themselves, which reflect the meanings of their culture. Thus, understanding narratives is fundamental to the practice of social work, and Holland and Kilpatrick (1993:308) suggest that reflective exploration of stories across many cultures is useful practice in working with clients from diverse backgrounds. Such exploration may enhance the capacity of social workers to understand and appreciate the diverse ways in which people develop meaning and express their problems-solving skills, resulting in creative and empowering ways to re-author lives.

Soal and Kottler (1996:123) discuss a South African study with a social constructionist quality, which suggests that problems experienced by families cannot be seen to have an objective existence or to be 'within' the family unit. Rather, the problems presented by families are shaped by an investment in socially constructed discourses which ascribe meaning to experience. These authors conclude that local families experiencing problems cannot be viewed in isolation from the dominant discourses that pervade the South African social order. In the process of challenging dominant beliefs, it is suggested that narrative family therapy has the potential to assist families to question "…regimes of truth" that determine their experiences and subjugate their lives (Soal &

Kottler, 1996:133). The researcher is of the opinion that the usefulness of social constructionist concepts in understanding the dominant discourses, and how they shape family narratives is very relevant to the unique context of South Africa.

The family therapy approaches described above predominantly focus on contextual factors, highlighting the view that people may be predisposed to the development of behaviours and beliefs because of factors in their history, the wider social network or personal constitutional factors such as genetic vulnerability. Approaches which focus on the role of early experiences in the family-of-origin in the etiology of problematic behaviours and beliefs were explored, with experiential family therapy differing in that it includes both problem resolution and personal growth as therapeutic goals.

Multisystemic family therapy addresses factors in the wider social system, as well as individual factors such as skills deficits, while pscyhoeducational models consider constitutional and genetic factors in predisposing people to problematic behaviours and beliefs. Family therapy shows promise in working with families from diverse cultures, but requires awareness and understanding of such diversity.

The previous sections focused on the historical roots of family therapy, its evolution from inception to the present day, and on the various approaches to family therapy based on categories of behavioural systems, belief systems and contextual factors. In the section that follows, the focus is on intervention, based once again on the categorisation of Carr (2000).

2.5 INTERVENTION

Carr (2000:522) states that the results of research indicate that family therapy interventions are shown to be effective for child-focused and adult-focused mental health problems and relationship difficulties, and while it is suggested by Carr that postmodern practitioners in family therapy may object to the notion of evidence-based practice because of its modernist assumptions of objectivity, his position on this critique

is that postmodernism does not mean an abandonment of rigorous scientific methods of inquiry – rather, it requests that we accept the limitations of the findings of such an inquiry.

Certain criteria are suggested in selecting interventions for particular types of families and family issues. Interventions need to be compatible with the family's readiness to change. Where families are ambivalent or uncommitted, it is proposed that these issues be the focus of treatment, rather than on plans of action. In addition, intervention should be compatible with the family's rules, roles, beliefs, culture, as well as focusing on their strengths and resiliencies, in preference to those that fail to utilise family strengths and resources.

Sometimes interventions are selected because they are in fashion, even if evidence is lacking with regard to effectiveness. In other instances, unacknowledged countertransference biases the selection of intervention. This highlights the relevance of being self-aware and reflexive, otherwise the chosen therapies may inadvertently maintain the family problems rather than facilitate resolution. Essential too, is the need to consider when family therapy is called for, and when other services and referrals are necessary (e.g. medical intervention, psychiatry, social welfare) (Carr 2000:256).

Carr (2000:255) uses the categories of context, belief systems and behaviour patterns to delineate appropriate intervention according to the schools of family therapy. In keeping with his categorisation system, the researcher will use this as a guideline to briefly explore the various interventions within the context of the theoretical approaches. Gladding (2002:173-184), Carr (2000:257-273) and Worden (1999:128-152) describe many of the techniques used in intervention with families.

2.5.1 Interventions for Behaviour Patterns

The following interventions aim to disrupt or replace problem-maintaining patterns within the family:

- **Creating a therapeutic context:**

In every session the contract and rules for a therapeutic encounter are established and re-established, either implicitly or explicitly. This creates a climate which disrupts problem-maintaining behaviours, promotes collaborative problem-solving, and enables all family members to be 'heard'. Problems can be reframed and different perspectives explored. Tasks may be given to be completed between sessions (Carr, 2000:257).

- **Changing behaviour patterns within sessions:**

In sessions, families may be invited to attempt to solve an issue in their usual way. By observing these enactments (a typically structural technique), the therapist is able to witness first-hand the ways in which the problem is maintained. The therapist intervenes when the family becomes 'stuck', perhaps giving directives to coach family members in more effective ways to problem solve. Structural family therapy assumes the importance of clear intergenerational boundaries in effective family problem solving and therapists will use boundary-marking to prevent alliances across the generations (Carr, 2000:259).

- **Tasks between sessions:**

Families may be requested to complete tasks between sessions which aim to disrupt or replace problem-maintaining behaviour patterns. **Symptom monitoring** (a technique often used in solution-focused therapy) is useful to ask clients to record information about the presenting problem. Intensity rating, frequency counts, duration, etc. may be recorded, as well as intrapsychic and interpersonal events that occur around the problem. Information obtained should be monitored regularly and the family may be asked to speculate on reasons for changes in the problem. **Encouraging restraint**, often used in MRI therapy, is a request to stop trying to solve the problem in the usual way and to postpone any new attempt to solve it. **Practising symptoms** involves requesting clients to practice the symptoms of the problem (e.g. involuntary tics) in order to gain control over it. This can reduce anxiety and begin to allow the client to attain some measure of control. **Graded challenges or systematic desensitisation** may be appropriate in situations where clients' anxiety prevents the achievement of

certain behaviours (e.g. phobias). They may be invited to gradually work towards facing the threatening situation, using small steps to overcome the problem (Gladding, 2002:184). **Skills training** encompasses a number of aspects such as communication skills training and problem-solving skills. Therapists can model communication skills, however clients also need to be given an intellectual understanding of what is required. Many obstacles to effective communication exist, for example, interrupting, attributing negative intent to the other person, not listening, blaming, and so on. The challenge of communication skills training is positive encouragement for gradual improvements, rather than criticism for mistakes which may affect the therapeutic alliance and the modelling of effective communication. In problem-solving training specific guidelines are provided on how to: define the problem, deal with one problem at a time, brainstorm for solutions, evaluate options, implement a plan of action, review and revise if necessary. Often families may require communication skills training before embarking on problem-solving skills training. Again, positive feedback is essential, while criticism should be avoided (Carr, 2000:260-263).

- **Changing behavioural consequences:**

Derived from behavioural family therapy, the use of reward systems and behaviour control routines can be effective in dealing with child-focused problems. **Reward systems** use age-appropriate points, tokens, etc. earned during effective management of the problem, and backed up with tangible rewards or prizes after the agreed upon target is reached (Gladding, 2002:173). Guidelines for behavioural control skills include the targeting of specific negative behaviours. For example, the child is commanded to stop a certain behaviour, given two warnings if the behaviour does not cease, followed by time-out (appropriate to the child's age). No anger is shown or explanation given at this time. If compliance is achieved after the set time, the child is invited to join the parent again in a rewarding encounter. If not, time-out is given again. **Behavioural control programs** may be stressful and negative behaviour may initially escalate as children test their parents. Consistent application by both parents, support for the other parent, and family support for single parents are necessary to assist the child to achieve self-control (Gladding, 2002:176; Carr, 2000:268).

- **Invitations to complete tasks:**

According to Carr (2000:273), when inviting families to carry out the tasks described above, the therapist must consider that adherence and compliance to medical advice and treatment is around 50%, an estimate with which Brown-Standridge (1989:487) concurs - thus one can expect that about half the time the family will not cooperate with tasks. According to Carr, this level of expectation can prevent unnecessary self-criticism, client criticism and other counter-transference reactions. Brown-Standridge (1989:471-487) describes the parameters of task intervention and classifies them as: direct versus indirect; behavioural versus non-behavioural; and paradoxical versus non-paradoxical. This results in eight flexible therapeutic options that consider the family's willingness to try something different to promote change, e.g. direct/behavioural/non-paradoxical; direct/behavioural/paradoxical; direct/non-behavioural/non-paradoxical, and so on.

2.5.2 Interventions for Belief Systems

A number of interventions aim to transform belief systems and narratives that maintain problematic behaviour patterns, thus helping clients to develop more empowering beliefs about themselves and their ability to solve their problems (Carr, 2000:273-287).

- **Addressing ambivalence:**

Commitment to counselling may fluctuate over the course of therapy and resistance may occur because family members are ambivalent about the process of change. When this occurs the task of family therapy is to address this ambivalence, and suspend attempts to achieve the stated therapeutic goals. Clients need to explore the costs of maintaining the status quo and those of change, before returning to the issues that brought them into counselling. Understanding the nature of ambivalence and overcoming it without alienating family members is a challenge for the family therapist. Attempts to overcome, avoid or use ambivalence to produce change will be based on the practitioner's theoretical orientation. However empathy and acceptance of the ambivalence are essential to the therapeutic process (Gladding, 2002:97; Carr, 2000:274).

- **Highlighting strengths:**

The importance of formulating strengths and exceptions to problems is necessary during all stages of the family therapy process. Chronic problems can be demoralising and clients may feel powerless to change their situation. Highlighting strengths may reduce these feelings and enable clients to re-focus and construct a personal and family narrative that encompasses growth. **Relabeling** occurs when the therapist offers positive or optimistic labels for ambiguous behaviour as a substitute for negative attributions. **Pinpointing** is a way of drawing attention to frequently used but unacknowledged individual and family strengths (Gladding, 2002:121; Carr, 2000:275).

- **Reframing problems:**

Clients are offered a new framework within which to conceptualise a problem that enhances the likelihood of it being resolved. The problem is reframed in interactional terms (rather than individual terms), and as solvable rather than unsolvable. A shift to a new perspective is crucial to movement toward change in family therapy (Gladding, 2002:206; Carr, 2000:276).

- **Presenting multiple perspectives:**

Family members with different viewpoints may present either/or arguments and find a both/and position difficult to consider. Listening to multiple viewpoints on a problem allows the therapist to empathise with each family member, and understand a polarisation of perspectives that hamper problem resolution. The idea of presenting the family with multiple perspectives evolved from the work of the original Milan school and Tom Andersen's reflecting team – two distinct practices can be identified: presenting families with **split messages** that validate the differing perspectives, allowing family members to find a shared perspective rather than a 'right' one; **reflecting team** practice wherein the family are given the opportunity to observe the team reflect on the problem, speculated explanations for it, and possible solutions, i.e. multiple perspectives (Carr, 2000:277).

- **Externalising problems and building on exceptions:**

The aim of these strategies is to help clients separate the problem from the person, identify the effects of the problem on the person, identify situations when the person was able to modify or avoid the problem, and develop a self-narrative that empowers the client to overcome the problem. Externalising the problem may involve giving it a name to personify it. When change and mastery of problems begins to occur, clients are helped to consolidate new personal narratives and belief systems about themselves through questions that link exceptions and competency to their past and future (Gladding, 2002:252; Carr, 2000:280).

2.5.3 Interventions for Contexts

Interventions that aim to modify the impact of historical, contextual and constitutional factors or mobilise protective factors include the following (Carr, 2000:283-296):

- **Addressing family-of-origin issues:**

Unresolved family-of-origin issues may prevent family members from making changes. The following issues may be the focus of exploration: **major family-of-origin stresses** such as bereavements, separations, child abuse, social disadvantage, institutional upbringing; **family-of-origin parent/child problems** such as insecure attachment, authoritarian/ permissive/neglectful/inconsistent parenting, scapegoating, triangulation; **family-of-origin parental problems** such as parental psychological/drug/alcohol problems, parental criminality, marital discord or violence, family disorganisation. Clients may be invited to explore transgenerational patterns, scripts and myths relevant to their difficulties – a genogram may be a useful starting point to understand how family-of-origin issues may be interfering with effective problem-solving in the family-of-procreation. The genogram provides a visual representation of the family that is useful in tracking change in the context of historical and contemporary events (Gladding, 2002:130). **Re-experiencing** is a way to help clients create a context in which they can remember and re-experience highly emotional situations in which destructive relationship habits were learned, and integrate these into a conscious

narrative. Visualisation of specific memories and the accompanying affect, writing (but not sending) detailed letters, responding to an empty chair are processes which may allow the client to re-experience and respond differently to early formative experiences to allow them to gain control over destructive relationship habits. **Reconnecting** is a process of coaching clients to reconnect with cut-off family members – this involves accessing, expressing and integrating emotions that underpin destructive relationship habits, and may result in mutual understanding and forgiveness (Carr, 283-287).

- **Addressing contextual issues:**

It may be that factors in the family's wider social context are hindering progress. Such factors include: **changing roles** whereby family members may be invited to extend their role or include other roles where appropriate, e.g. a peripheral father may be requested to be more involved with the children; **building support** where lacking, perhaps in the form of self-help groups, extended family support, or community support; **rituals for mourning losses,** an uncontrollable aspect of the family lifecycle, may enable family members to be liberated from unresolved and paralysing grief and help them to alter their belief system to accept the loss – this is not to erase the pain of the loss but to unblock the grieving process and allow people to move on with their lives; certain behaviours (e.g. bullying in school) maintain children's problematic beliefs and **liaison with the home/school** may be necessary if the therapy is to move forward – all parties are invited to contribute to and collaborate on problem-resolution; **network meetings** can provide a forum within which the family and all involved professionals share information, resources, etc. in an effort to resolve issues in multi-problem families; **child protection** services may be required if the family are failing to respond to therapy and child abuse/neglect is suspected; **advocacy** may be called for to assist families dealing with issues in the larger social environment, such as poverty, housing problems, discrimination; **exploring secrets** - secrets may be individual, known by some family members but not all, or known by all the family but kept from the community, and can be destructive in nature – secrets offered to the therapist in confidence by one family member may have implications for the family and need exploration of relevance to the problem, consequences to keeping the secret, possible

reactions of family members, issues of atonement and forgiveness (Carr, 2000:287-295).

- **Addressing constitutional factors:**

Constitutional factors such as injury, debilitating somatic states, learning difficulties or difficult temperaments may render therapy less beneficial and psychoeducation may be called for. **Psychoeducation** provides families with information about the problem, engenders hope by giving feedback and focusing on family strengths and protective factors, and promotes adherence to medical regimes (Gladding, 2002:179; Carr, 2000:295).

According to Carr (2000:298), the selection of intervention should ideally be based on empirical efficacy, therapist skill, and an awareness that family therapy may not be the most appropriate intervention in all cases.

Interventions may be categorised in terms of a particular area of focus. Some interventions aim to disrupt problem-maintaining behaviour patterns, others to transform belief systems and narratives that underlie these behaviours, while the last category explored the impact of historical, contextual and constitutional predisposing factors, and the types of intervention that assist in addressing these factors.

In keeping with the belief that theory must be an embodiment of the self of the therapist, any attempt made by the researcher to integrate any of the concepts of the different approaches would be presumptuous. Integration, if considered at all, would of necessity be a personal, unique and individualistic exercise that fits with the sense of reality and authenticity of the therapist. However, it may be of interest to the reader to consider the views of certain authors with regard to the notion of integration of modern and postmodern ideas, and in the next section their viewpoints are briefly considered.

2.6 INTEGRATION

According to Auerswald (1987:322), of the five paradigms in the field of family therapy, the first (psychodynamic) has been largely abandoned by family therapists, while the second to the fourth (family systems, general systems and cybernetics) have merged into what is known as family systems theory. The last paradigm (ecosystemic) is based on New Science which proposes a view of alternative realities – this has major implications for how we organise our knowledge base, how we think about families and how family therapy is practiced.

Auerswald (1985:4-5) draws some parallels between the New Science/physics and Newtonian physics. In the former, a monastic (both/and) universe is assumed; linear causative relationships are not established; abstract ideas are part of the field of study; certainty is discarded and truth is seen as heuristic. With regard to the latter, a dualistic (either/or) universe is assumed; linear causality is accepted; the field of study is mechanistic; certainty is accepted and truth is absolute. Auerswald (1987:325) believes that family therapy based on ecosystemic epistemology is radically different from Western/Newtonian thinking. Traditional concepts are pragmatic, reductionistic, medical-model based and researched on the basis of usefulness. On the other hand, an ecosystemic paradigm is usable in the design of community-based and human service delivery systems, and according to Auerswald, as a basis for solutions to even larger human problems.

Kvale (1992:1) poses the question of whether the modern social sciences (psychology and social work) can be developed and enriched by drawing on postmodern knowledge, or if the latter undermines and transforms modernist thinking. Similarly, Geurin and Chabot (in Carlson & Kjos, 2002:156) question the future of the family therapy movement as the "…pioneers…" make way for a new generation of family therapy practitioners. These authors see the goal of family therapy as the development of an integrated system of interventions that will enhance the ability of the practitioner to

guide the process towards the growth of the individuals within the family, as well as the family as a whole.

Rivett and Street (2003:48-49) discuss the work of Larner who provides an integrative model of modernism and postmodernism, and Pocock who explores the difficulties of a single theory to best explain a family's difficulties. The suggestion is that family therapists should not be forced to choose between a cybernetic or discursive theory, but encompass both. The complexity of working with families means that we cannot afford to dismiss any theoretical ideas available to us – any and all ideas should be used to serve the therapeutic process. This view highlights for the researcher the necessity for family therapy practitioners to have a sound theoretical knowledge base from which to draw, as well as the self-awareness of knowing which ideas are an authentic fit. Thus, an understanding of one's paradigm is essential – without such an understanding one runs the risk of being swayed by every passing whim, or of rigidly adhering to a particular position with little consideration of its relevance to the client family. Pocock (in Rivett & Street, 2003:49) believes the overriding issue is which model is congruent for the family, suggesting that a particular model is to be favoured only if it is clinically useful at a particular moment, to a particular therapist, with a particular family. The complexity of family dynamics and thus family therapy means we can ill afford to dismiss any theoretical ideas available to us. According to Rivett and Street (2003:51), postmodern family therapy practice is "…one story but it brings as many paradoxes and contradictions as any other story".

In a paper that attempts to combine a 'both/and' approach to family counselling, Atwood (1995:1) explores how traditional and constructivist thinking that operates from an 'either/or' perspective leaves out half the picture – traditional approaches operate from a deficit standpoint, while in opposition, more solution-focused therapies focus on strengths, competencies and resources. Amundson (1994:87) also suggests that to argue for the ascendancy of one approach over another is to miss the point, and that we can explore the unity of certain experiences while appreciating diversity.

According to Bertrando (2000:100), the conflict between text (language) and context, and between the narrative and systemic metaphor may impoverish family therapy. His synthesis of the two ways of thinking views **text** as useful for understanding the subjective, idiosyncratic meaning dimensions of experience, while **context** is useful in understanding the parts of our experience of which we tend to be unaware. Shifting between the two can enrich the client-therapist relationship. Bertrando (2000:84) sees value in the introduction of narrative/constructivist thinking in systemic therapy, such as respect for people's stories and ideas, but believes that taking an either/or position by embracing one approach and rejecting another obscures the "…most precious contributions of both".

A compatible view is held by Gergen (in Hoyt, 1998:xiv) who states that despite the problematic ground on which modernist therapies were grounded, they can be viewed as contexts for the generation of meaning, and continue to have relevance for significant sectors of the therapeutic culture. The aim of constructive therapies is to broaden the way in which transformation is achieved, and thus according to Gergen, there is no reason to exclude traditional therapies which may expand dialogue. According to Rivett and Street (2003:47), the difficulties of adopting postmodern ideas in family therapy have been recognised in the field, and attempts have been made to integrate modernist and postmodernist ideas into a framework that allows co-existence and movement between the two, thus celebrating difference and ambiguity.

Dallos and Urry (1999:163) view social constructionism as offering some "…important departures but also connections and continuities…" rather than signalling the end of systemic therapies. However, they believe there are important practical, ethical and moral issues attached to the differences between first and second-order approaches that require recognition if we are to attempt to integrate them. Awareness of difference does not imply a rejection of one position, but rather a contrast of positions. These authors go on to suggest a number of key organising themes (Dallos & Urry, 1999:164):

- Theoretical assumptions

- Theoretical links and connections
- Views of problems and pathology
- The role of the therapist
- Views of individuals and individual experience
- Ideas about the nature of family relationships
- Development and change (both natural and therapeutic)
- Moral and political implications

Dallos and Urry (1999:165) suggest three stages in family therapy theory development: a first-order perspective that focuses on patterns and regularities in families' lives and experiences; a second-order view which focuses on meaning and uniqueness; and a third-order perspective which allows the family therapist to consider the rules and predictability of family life, while recognising that this is socially constructed by the cultural context.

Not all authors are equally in favour of postmodern ascendancy, or even of integration. In an article that questions the postmodern trend, Pilgrim (2000:7) states that the affinity between family therapy and postmodernism is understandable for a number of reasons. Both explore ambiguity and shifting interconnections, with diversity of perception within a range of family relationships. Postmodernism may appear to unify conceptual thought that in fact "….simply disguises differences" (Pilgrim, 2000:8). Pilgrim believes that postmodernism will fail family therapy, basing this view on a lack of confidence in its practical utility and the unlikelihood of it providing an intellectual foundation for clinical practice. Systemic thinking in family therapy retains a strong presence and according to Pilgrim (2000:11) is a relevant reference point for postmodernism.

Speed (1991:398) sees the value of constructivism in its emphasis away from viewing one model of therapy as the absolute truth, but feels the movement has gone too far in its assertions that reality has no relevance to what we know. She proposes a co-constructivist stance which holds that both ideas and reality contribute to knowledge.

Speed (1991:398) goes on to state that we can never know reality, we can only have views on reality – however, reality can be discovered in an objective way which determines what we know. Thus, reality is reflected in knowledge.

Applying a co-constructivist epistemology to family therapy implies therapist and family constructing an account of events, patterns and problems – this account is one possibility of a number of possibilities, but according to Speed (1991:403), there are not infinite possibilities. If we adopt a co-constructivist position, i.e. acknowledging the contribution of ideas and a reality to what we know, Speed (1991:405) believes this has implications for practice. The first is that we have a responsibility to be aware of how our ideas determine what we see, and the second is to research the reality of what exists, which determines what we know.

According to Minuchin (1991:50), the strength of the constructivist approach is its emphasis on the limitations of therapy and the realisation that truth is always partial. His objection to constructivist therapy, is its emphasis on the idiosyncratic story of the family which ignores the implications of the social context of their lives, i.e. poverty, disease, class, race, gender and many more factors. Therapy cannot be only a matter of inventing new and better stories.

Minuchin (1991:50) sees it as ironic that constructivists, with their appreciation of multiple realities, seem to have forgotten the "…richness…" of family therapy theories, techniques and interventions, and the field's diversity and eclecticism. He refers to a "…treasury of therapies…" that the skilled family therapist is able to draw on to enrich their work and the lives of their clients. Hanna and Brown (1999:4) prefer to use the word "…integrative…" rather than eclectic, believing it relates to making connections between parts. They see the field of family therapy as diverse, but with a history of integration.

Anderson (1999:2) quotes Minuchin's suggestion that postmodern theory should be examined with a "…critical eye", but her own view is that any theory of family

functioning should be examined with a critical eye. She sees critical examination as integral to a postmodern paradigm, in particular its critique of metanarratives and the belief that one description is 'truer' than another. Anderson (1999:3) disputes claims that the postmodern paradigm is a 'fad', believing it to be an extension that goes beyond the "…original gift of family therapy".

According to Eron and Lund (1993:291), the postmodern movement has challenged the foundations of structural and strategic approaches. However these authors question the differences of the approaches, and suggest that the new orientation is merely an elaboration of old ideas. Many of the aspects of strategic therapy, such as joining with the family, starting where they are and harnessing resources to facilitate change have strong postmodern overtones. In addition, Eron & Lund (1993:293) question whether terms such as 're-storying" and 'co-creation" are more enlightened than the more old fashioned term 'reframing', and suggest that it matters less what terminology is used to describe a redefinition of a problem, than that this definition has meaning for the family. Narrative therapists could perpetrate the very same transgression they accuse the strategic therapists of doing, namely, inventing their own new realities and imposing them on clients while reframing this as co-construction. Eron and Lund (1993:293) believe that in combining the "…richness and breadth of scope of the narrative perspective with the precision of a strategic approach" many advantages are to be had.

Mills and Sprenkle (1995:372) suggest one need not abandon strategic interventions in order to honour second-order principles such as respect for clients and the place of the therapist within the system. Strategic concepts may be appropriate when informed by second-order thinking that openly acknowledges them as ideas that may or may not be helpful to families. Bertrando (2000:85) believes that theories develop through "…epigenetic evolution…" as does the therapist. He states that to adopt a postmodern position wherein not having a preferred theory is 'correct' while having one is 'incorrect' imposes a prescription on the therapist that risks losing the many positive sides of modernist theories.

Gibney (1999:31) believes that one of the ambivalent legacies of Bateson's influence in the development of family therapy is his ability to draw from other disciplines, which this author believes Bateson did with sensitivity and a regard for context. However, many family therapy theorists evidence an "…undisciplined borrowing…" from other fields with little explanation as to why, and for what purpose. In the opinion of the researcher this has relevance for the practice of family therapy at the organisation under study. The eclectic use of techniques holds both advantages and disadvantages, contingent on the depth of theoretical knowledge, as well as capacity for reflexivity of the family therapy practitioner.

Goldenberg and Goldenberg (2000:113) state that the borrowing of techniques from different schools must be based on the therapist identifying the theoretical orientation from which he/she operates, before using interventions that are congruent with that theory. These authors explore the controversy of integration, suggesting that there are many inherent incompatibilities in the major theoretical constructs of the major theories for such conceptual integration to be undertaken. Different schools of thought have different assumptions about human nature, different goals, and different criteria for evaluating success. Goldenberg and Goldenberg (2000:113) go on to state however, that theories are hypotheses offered in the hope of solving a problem of family dysfunction. Thus they are never true or false – they are all tentative.

According to Anderson (1999:7), the postmodern perspective "…invites self-reflection on our traditional beliefs…" valuing multiple voices, diversity and difference. In addition, postmodern beliefs value connection and response to the broader socio-cultural context. The aim is not to subvert or dispense with earlier thinking about working with families but to reconceptualise practice in terms of how we are and want to be in relationships with others. The postmodern perspective accommodates traditional theories, and according to Anderson (1999:7), offers the potential for extending their potential. It is not an abandonment of tradition, more an extension of the ideological shift that family therapy initiated. Gergen (in Anderson, 1999:7) states that social constructionism is not antithetical to tradition, and that tradition is in fact

"…essential to the construction of all meaning". Postmodernism challenges us to continue the practice of "reimagining" which implies consideration of the new, the expanded and the revolutionary as opposed to the acceptance of the traditional and the known, in other words, what family therapy has always done and what will take us beyond (Anderson, 1999:7-8).

In conclusion, postmodernism has ensured that family therapy remains sceptical of its assumptions, respectful of the unique solutions of families, and according to Rivett and Street (2003:51) has brought "…the reflexivity of the therapist into central stage".

2.7 SUMMARY

In this chapter the epistemological revolution that constitutes the historical basis of family therapy was explored, from the concepts of a first-order cybernetic view to a postmodern paradigmatic shift. Various scientific and clinical advances paved the way for family therapy to advance, including general systems theory, the role of the family in personality development, marital and child guidance in mental health, and group therapy as an intervention.

The evolution of family therapy over the decades, beginning in the 1950s to the present day was explored, as well as the growth of family therapy within the South African context.

A review of the numerous different approaches to family therapy detailed the various schools of thought, based on the classification system of Carr (2000) (but including feminist and existential approaches) whereby theories are categorised according to their fundamental focus of concern, i.e. behaviour patterns, belief systems and context. The review considered aspects such as the basic premises of each approach, founders or major proponents of the approach, typical concepts and techniques, views on assessment and treatment, and the role of the therapist.

Family therapy interventions within the context of the various theoretical approaches were described, again grouped according to the focus of concern, namely, behaviour patterns, belief systems, and context.

Finally, the viewpoints of various authors on the subject of integration of modern and postmodern thinking were explored.

The following chapter explores the reflecting team as an approach to family therapy intervention. Reflecting team practice involves a team of family therapists and the family in a collaborative, therapeutic process.

CHAPTER 3

THE REFLECTING TEAM IN FAMILY THERAPY

3.1 INTRODUCTION

The use of teams in family therapy occurs in many schools of therapeutic intervention (i.e. structural, strategic, Milan) although they are used in different ways. The reflecting team model was first introduced by Tom Andersen in the 1980s as an alternative to the Milan style team whereby clients received a message from the team, delivered by the family therapist (Biever & Gardner, 1995:47). The use of the reflecting team allows the client family direct access to the perspectives, ideas and speculations of the team members. The team share comments on the conversation between client and therapist while the family watch and listen. This is followed by the family having the opportunity to explore the team's ideas and viewpoints, and to see if any of these have meaning for them, either as individuals or as a family. While this gives a postmodern flavour to the prospect of family therapy, the researcher is of the opinion that many approaches could be, and in fact are, incorporated into this method of family therapy practice. Ideas about behavioural change, roles, structure or family cognitions and so on, could be considered in the reflecting process and the team's speculations could prove meaningful to some or all of the family members, and thus facilitate change. The difference in a reflecting team process relates to the generation of dialogue and thus possibilities for the family to consider, rather than a statement of facts about how things are or should be.

The purpose of including a chapter on the reflecting team process in family therapy is because it is the format used at Family Life Centre, for both training of new family therapists as well as being the vehicle for the provision of family therapy to the client families. In addition, the perception of the researcher is that reflecting team work

provides an invaluable opportunity for consideration of one's theoretical position, as well as for reflection on the self of the therapist. Although the obvious and major objective of the reflecting team process is the contemplation of multiple perspectives that may have significance for the client family, the 'by-product' is the opportunity to witness other family therapists in action, observe different approaches in practice and be able to reflect on whether or not these fit with one's own self, as well as contemplate the possible impact of the self on the family both as therapist and as reflecting team member. The provision of an environment that is both supportive and challenging facilitates discussion of theory and issues relating to the self within the context of the reflecting process.

In this chapter, the concept of dialogue within the context of the therapeutic conversation will be addressed, after which the work of Tom Andersen will be explored in light of his own paradigm shift in working with families. Some guidelines suggested by Andersen for the practice of the reflecting team process will be elucidated and presented.

In the section that follows, the works of various authors on the reflecting process will be discussed, with attention given to the goals and guidelines that illustrate the way in which reflecting teams operate, as well as a discussion relating to the reflecting team in a training setting. Various issues concerning hierarchy and power dynamics in family therapy, aspects relating to reflecting teams from a narrative framework and consideration of the occasions when reflections may not be useful to the family will be highlighted.

The use of peer reflecting teams, also referred to as outsider witness groups in narrative terminology, will be considered. Finally, the theme of reflective thinking will be contemplated as an integral aspect of the development of the self of the therapist.

3.2 DIALOGUE IN THE THERAPEUTIC CONVERSATION

Anderson (2001:112) states that language, both spoken and unspoken, gains meaning through its use – it is the primary vehicle through which we construct and understand the

world. A dialogical conversation refers to one in which people talk **with**, rather than **to**, each other. Its value lies in equal contribution and shared expertise that facilitates a "…generative process…" involving exploration of the familiar and construction of the new. The consequence of such a dialogical conversation is transformation (Anderson, 2001:112).

According to Seikkula, Aaltonen, Alakare, Haarakangas, Keranen and Sutela (1995:65), the monological language used in traditional therapy settings consisted of ideas, plans and decisions made by the team, with the family having little, if any place in the process. Dialogical language engages the family from the very beginning of the therapeutic process. Monological forms of interaction are a specific part of dialogue and not necessarily opposite to it. Seikkula *et al.* (1995:66) state that in monological dialogue the utterances are "…closed circuits…" which prohibit the flow of questions and shut down discourse. Because the monological utterances are either acknowledged or denied there is no possibility of combining or integrating them to produce alternatives. An example is described by Siekkula *et al.* (1995:66) wherein a monological dialogue occurring in a diagnostic interview is aimed at the elicitation of information to confirm or reject a hypothesised diagnosis. As long as this search for answers is aimed at an acceptance or rejection of the hypothesis, the interactional context remains monological. According to Andersen (2001), monological dialogue is hierarchical – the expert asks the questions while the other party answers. Dialogical conversation is democratic – all parts influence each other and while the parts are not equal since they come from different backgrounds with different experiences, they have equal right to influence how they collaborate.

The monological language speaks about the already spoken and seen world, while the dialogical language speaks about a world that is open, unready and unspoken or yet to be spoken (Seikkula *et al.,* 1995:67). What is spoken is a response to a previous utterance, and awaits another utterance to provide the answer. This sequence is never completed as in a final outcome being attained. New meanings arise whenever conversations are started and the discourse become true in the moment of being spoken.

Seikkula *et al.* (1995:67) quote Volosvinov who states that in the dialogical conversation the answer is the outcome of the utterance without which the dialogue is incomplete. The understanding in language originates in the dialogue and without understanding cannot be expanded. In dialogical conversation the language is constructed between the speakers, and thus the creation of meaning arises through language. In a therapeutic conversation the meanings of the client's experiences are constructed between the therapist and the client, and according to Seikkula *et al.* (1995:67) these discourses may expand the already spoken reality and construct new perspectives. Therapy becomes a dialogical process, both public and participatory, thus allowing ideas to flow in a recursive way (Friedman, 1995:4). The growth of understanding goes hand in hand with dialogical conversation and thus the most important skill according to Seikkula *et al.* (1995:75) is the ability of the reflecting team to generate dialogue.

Within the context of reflecting team work used at Family Life Centre, the researcher concurs with the expressed opinion of the abovementioned authors. The generation of dialogue within the reflecting team, witnessed by the family, brings forth a plethora of diverse perspectives and ideas. The curiosity and interest of the researcher is constantly piqued in the observation of those aspects chosen by the family that have meaning for them, and which perhaps create a new perspective on an old issue. The experience of collaboration allows the client family to own the process and serves as a medium for the generation of new alternatives.

In conclusion, a dialogical conversation engages the family as co-creators of the therapeutic journey which may provide alternative meanings and solutions to a problem situation. The generation of dialogue is the vehicle through which this journey is travelled. In the process of dialogue and listening to different meanings, new ideas may emerge.

3.3 TOM ANDERSEN'S REFLECTING PROCESSES

According to Friedman (1995:4), Andersen underwent a personal journey and evolution with regard to reflecting team work. Believing that people are in an ongoing process of formation, Andersen views the client as a collaborative co-researcher in the development of new possibilities.

Andersen (1995:11) explores his shift in perception of what he refers to as "…reflecting processes…" from an intellectual one to one as a consequence of feelings. This shift was in response to his feelings of "…discomfort as a therapist…" when being with others (i.e. a client family). Andersen favours the hermeneutic tradition with its assumptions regarding knowledge as bound by context, time and person (Andersen, 1995:12). Hermeneutics refers to the understanding and interpretation of meanings in everyday human behaviour. It is the art or skill of interpretation and according to Rubin and Babbie (1993:362) is the process in which patterns are sought amidst "…voluminous, and perhaps chaotic, details".

The hermeneutic concept represents the ideas of Heidegger and Gadamer, wherein assumptions are made, based on past experience. What we understand influences our interactions with our surroundings, and relates to what we see and hear. In the act of creating meaning, we also choose to limit what we see and hear. This invites "…prejudice…" or "…preunderstanding…" of a person or situation. New information may change our preunderstanding, which in turn influences the actual understanding – this in turn influences the preunderstanding and thus we have the concept of the **hermeneutic circle** (Andersen, 1995:12). According to Andersen (1995:13), reflecting processes may be seen as hermeneutic circles. In other words, the contemplation of different ideas may change the original meaning and thus change our basic assumptions.

In exploring his own shifting perspective, Andersen (1995:15) quotes Bateson who made the statement about change as "…a difference makes a difference". Andersen goes on to suggest that what is "…appropriately unusual…" makes a difference while the too

unusual or similar fails to make a difference. Such nuances are viewed as applicable to many situations, including conversations. In addition, Andersen learned to go slowly, waiting to see how clients respond before saying or doing the next thing, picking up the cues that something is too unusual and which leaves the client feeling uncomfortable. These ideas were a "…prelude…" to the first reflecting team in 1985 (Andersen, 1995:15).

Initially, Andersen worked using the Milan approach, but a shift occurred in the way in which he and his colleagues intervened with families (Andersen, 1995:16). Previously they had tried to find the 'correct' interventions, leading to a power struggle with the family if they disagreed – an either/or position. Andersen disliked the notion of 'expert' ideas from the team and questioned the ethics of hiding team deliberations from the family. The shift to a more democratic stance led to the idea of "…open talks…" which reflected the views of the team in the presence of the family. This resulted in open dialogue that was respectful and natural, rather than professional and detached (Andersen, 1995:16).

In a session with a family which was characterised by despair and hopelessness, Andersen and his team attempted the first 'swap' with the family, putting the team in the limelight, so to speak and giving the family the opportunity to observe their reflections. This early attempt at a reflecting team seemed to create such change in the family, from despair to hope, that Andersen and his team began to use this method on a regular basis. Early efforts to describe the process coined the word "**heterarchy**" (the opposite of hierarchy), implying democracy and equality (Andersen, 1995:17-18). In another article Andersen (1996:120) describes shifting from an 'either/or frame' to 'both/and', which lessened battles between therapist and family, where previously families had sought to defend their ideas against interventions that had no meaning for them. In this way the idea is conveyed that the problem has many aspects and is multifaceted, and according to Andersen (1987:427) the family and team can discover the "…richness… in the sharing of various points of view on the same issue".

It could however, be argued that the family may not want a 'non-expert' position from the team. For some people, seeking professional help may mean an expectation of an opinion other than that already sought from friends and relatives, i.e. equals. They may want a more authoritative perspective, and may feel cheated if this is not forthcoming. From the perspective of the researcher, the value of the possibilities generated in the reflecting team process may assuage such a need, and while ideas are not presented as expert opinions, the dialogue may offer something different from what has thus far been considered.

Hierarchical systems create a win/lose situation that may create a position of dominance and submission. Cohen, Combs, DeLaurenti, DeLaurenti, Freedman, Larimer and Shulman (1998:280) explore some ways of minimising hierarchies. These include: not talking about the family outside of their presence so as to maintain respect; asking questions from a position of curiosity, rather than making statements, which creates a climate that honours the voices of the family members. In addition, striving to avoid assumptions helps to minimise a hierarchy wherein the therapist's worldview constructs the therapy through the imposition of personal values and beliefs. White (in Cohen *et al.,* 1998:280) refers to **transparency** which we practice by letting people know how our thoughts and intentions are shaped during the therapeutic encounter, rather than presenting 'expert' knowledge. According to Hoffman (1998:104), the transparency of a reflective conversation demands a high tolerance for vulnerability on the part of the therapist because it means exposing one's own thought processes.

Other reflecting processes can be described as shifts between talking and listening – **outer talk** involves talking to others, while **inner talk** occurs when we talk with ourselves whilst listening to others. This process sifts issues through a number of perspectives which may be put together to create new ideas. Andersen (1996:120; 1995:18) emphasises the concern of Bateson regarding the necessity of multiple perspectives about the issue in focus during the therapeutic encounter. Hoffman (1998:106) describes the process of Andersen's reflecting team as the continual "…folding over…" of personal thoughts and feelings of the family and team which

creates a "…benevolent environment". The only goal is to continue the conversation, without prescriptions and strategies. Clearly this last comment by Hoffman has implications for the family therapy practitioner – comfort with process and with not taking the expert role is evident.

From the perspective of the researcher, the family too has an opportunity to take a reflective position with regard to the shift between talking and listening. During the therapy session family members engage in outer talk, speaking to one another, listening, responding and so on. When the family listen to the deliberations of the reflecting team they engage in inner talk – they can listen, absorb and reflect on what has been said with regard to how others (the team) see their situation.

Andersen (1987:426-427) elucidates on the differences between the reflecting team as he practices it, and the more strategically orientated team of other forms of family intervention. The type of reflecting team used by Andersen emphasises team members as participants in a process in which family members are equals, and an acceptance of being part of the therapy process, rather than believing the therapist should control it. Trainees who are part of the team determine their own level of participation, often starting with few speculations but sharing more as experience grows. Unlike the Milan approach, no hypothesis is made prior to meeting the family as this may influence perceptions and preclude understanding of the "…frame…" that preoccupies the family members. Interventions are also avoided, since family members may believe these to be better than those they had envisaged for themselves. In reflecting team practice, the team is no longer the unseen 'expert' suggesting interventions and even prescriptions to the family.

It is thus apparent that Andersen became disenchanted with monological and hierarchical systems that allowed no room for the voices of the family to be heard above that of the 'experts'. Andersen's own growth as a family therapist is reflected in his sharing of his personal journey and the way in which he came to practice reflecting processes.

3.3.1 Andersen's Guidelines for the Practice of a Reflecting Process

The general guideline for reflecting team work is the story metaphor, whereby people make sense of their lives by situating them in stories. In the context of therapy, people can reauthor their lives by generating new meanings for events. Members of the reflecting team focus on differences and events that do not fit the old story, thus opening up space for a new one. The deconstruction of beliefs and ideas that may perpetuate the old story may also be a focus of exploration by team members. Andersen (1995:19-21; 1987:424) suggests some guidelines for the practice of a reflecting process, while Lax (1995:160) constructed a summarised version of Andersen's procedures. For convenience, these are combined in the following points:

- The less planned the process, the greater the possibility of allowing the situation to assume its own shape or form. It is essential that the people participating in the reflecting process feel able to say and do what is natural and comfortable. Andersen emphasises too that the family is at liberty to agree to listen to the reflections, or to refuse, and that even agreement does not imply having to listen in the moment. Speculations are restricted to conversations that have taken place in the session.
- Andersen refers to how he himself prefers to be, as a participant in the reflecting team. He likes to speculate about something heard or observed in the family's talk with the therapist, and to talk in a questioning manner. Ideas are presented tentatively using phrases such as "perhaps", "possibly", "I was wondering" and so on. Conversation is to develop ideas rather than a competition for the best idea. Statements, opinions and meanings are avoided – meanings can be construed by the family as something they should consider or even do, perhaps given additional weight as 'better' than the family's meanings, or even experienced as criticism of their own meanings. If strong opinions are expressed by a team member, Andersen will open this up for dialogue, and explore how the opinion fits with the perspective of the various family members.

- Andersen feels he is free to comment on all that he hears, but **not** all that he sees. People have a right to not talk about all that they think and feel; hence comments on non-verbal behaviours require circumspection.
- Andersen recommends that the members of the reflecting team talk with each other and not include the family in the talk – talking with them or looking at them forces them to listen to the team member/s, restricting their choice of whether to listen, or to not listen and allow their mind to wander. Thus, without being discourteous, team members maintain eye contact, separating the listening and talking positions.
- Andersen (1987:424) issues a warning that connotations always be positive and that every "…normative judgment…" be excluded by the reflecting team. His belief is that the one-way screen tends to magnify criticism and questions of the "why did they do this or that" variety, and comments on the behaviour of family members may expose sensitive areas that they do not wish to talk about. The team must be protective and careful of the family 'betraying' more than they may have wished or realised. Thus the reflecting team must remain positive, discreet, respectful, sensitive, imaginative and creative.
- Reflections attempt to present a 'both/and' position with regard to an issue, shifting away from an 'either/or stance'. Therapists should use the language and metaphors of the family, avoiding diagnostic and psychological terminology.

For Andersen (1995:21-22) a number of questions emerge from these guidelines, some of which remain private and some are shared with the family. The first (private) concerns the appropriateness of the "…unusual…", and how the family is responding to it – this involves self-reflection of the process and perhaps the need to change either the manner of talking or even the topic. For the researcher this highlights once again the need for self-awareness and understanding of one's own motivations in the therapy process.

The second and third questions are shared and are significant in the first meeting with the family. They concern the idea of how the family came to the session – who had the idea, how others responded to it, who wants to talk and who doesn't. Also of concern is how the family members would like to use the meeting. This allows for many different

perspectives, and enables the therapist to talk about what the family would like to explore, and not create his/her own agenda.

The final question may or may not be shared with the family by Andersen, and involves new issues that may create tension. People are not always ready to explore an issue at the same time, and Andersen questions who can/cannot talk at this point in time, thus facilitating choice in engaging in the process.

Andersen (1995:22) refers to the problem-created system (the concept of Anderson and Goolishian), whereby a problem attracts attention from others, i.e. family members, friends, therapists, official persons. These people create a system of meanings about how the problem can be understood and solved. Meanings may create new and more useful meanings, or they may constrict dialogue and inhibit conversation. According to Andersen (1995:22), it is safer to explore existing meanings with the family than to bring more meanings to complicate the picture. However, Andersen (1987:415) also states that a 'stuck' family system needs new ideas in order to broaden perspectives, and the task of the reflecting team is to create ideas even though these may be rejected by the family. What is important is that the family will select the ideas that fit, and that may pave the way for a change in understanding (Andersen, 1987:421).

The creation of meaning forms the basis of most approaches to psychotherapy and according to Lantz (1993:7) meaning and family interaction have a "…close and reciprocal relationship". The awareness of meaning can stimulate healthy family interaction, which in turn can stimulate increased awareness of meaning to be found within the family. A lack of awareness about meaning within the family can result in a meaning vacuum which has the potential to be filled with either a developing sense of meaning or with greater forms of dysfunctional interaction which further cloud the awareness of meaning (Lantz, 1993:8).

In his discussion of Andersen's work, Lax (1995:161) refers to new information that is stimulated by the therapeutic conversation, but is "…tangential to it". Andersen refers to

these as "surprise comments" that initially seem too unusual to the family but when prefaced with an explanation of how the therapist arrived at this idea, may make more sense to the client. Surprise comments may open up conversational space to challenge the preconceived discourses of both client family and therapist.

According to Lax (1995:161), there may be times when reflecting team members share the same idea. However, if only one idea is presented to the family, they may believe it to be the only option. The emphasis is on a "…smorgasbord of ideas…" rather than a limited presentation. One way to avoid a restricted presentation is to limit talking by the team members watching the interview, thus preventing their influence on one another's thinking and perceptions prior to the presentation to the family. Hoffman (1998:107) shares her amazement at the ability of the reflecting team to generate images and metaphors, as well as feeling freer to share personal experiences where appropriate and to show feelings. This observation resonates strongly with the researcher – it is 'amazing' to be part of a process that generates ideas that can be seen to have meaning for family members in the therapeutic encounter, and may contribute to positive change.

In exploring the meanings that family members hold, Andersen (1995:23) stresses the importance of allowing time for members who want to speak, and not interrupting them. Undisturbed monologues often reveal shifts between inner and outer conversations, in the search for meaning. The accompanying non-verbal behaviours indicate when words have particular meaning for the person (Andersen, 1996:121; 1995:23). Hoffman (1998:105) also comments on situations where one member speaks at length while the rest of the family just sit back. Some family therapists, such as Haley, viewed this as doing individual therapy in a family setting. Hoffman however (1998:105) describes Harlene Anderson's belief that in one's own attentive listening, family members are enabled to listen in a less judgmental way. In family therapy practice at Family Life Centre, the researcher has also observed that family members often hear things for the first time, or hear them in a different way after a family member has explored an issue.

Questions by the therapist search for "…what is inside the expression; in the word; in the feelings; in the movements…" and require listening to what is heard and seen without reading more into what has been said. Andersen (1995:25) states that there is "…nothing more in the utterance than the utterance". In addition, the interviewer who remains with the family follows their reactions to the reflections of the team. Such reactions will indicate whether or not the reflections are positive, if they help to "…expand the ecology of ideas…" or if they are too unusual (Andersen, 1987:422).

Andersen (1987:423) goes on to suggest that members of a stuck family system 'protect' the team by not expressing any negative reactions or responses to the team's reflections. Questions around what the family liked, disliked, were or were not interested in can be useful in enabling the family to explore their reactions to the feedback. Observation of negative responses to something that was said by the team may be explored by asking the family members about what may have been difficult to listen to or think about. Feedback of this nature may help the team to consider whether it has strayed outside the limits of what is appropriate for the family. Andersen (1995:26) stresses that the questions be appropriately unusual, and not too unusual, and to be alert to the signs that the person feels discomfort or not.

An aspect that Lax (1995:161) believes has received little attention is the role of modelling that is inherent in the reflecting process. The demonstration of value in multiple perspectives, a both/and position, attentive listening to the views of others and respectfulness, allow team members to provide a different experience for family members. Differences of opinion among team members can be explored using phrases such as "I have some other thoughts about that", emphasising that these are in addition to and not opposed to. Lax (1995:162) believes this is augmented by encouraging the family to ask questions of the therapist and team members during and after the interview, allowing them to inquire about dominant discourses, perspectives and ideas, and gain an appreciation of interaction in the session and in life.

Andersen (1995:26) explored ways to increase therapists' sensitivity to their contribution to the therapeutic encounter. This involves asking clients to discuss their experience of the therapeutic meetings and outcome. This may involve the presence of a colleague who may ask the therapist about what they wish to focus on or clarify, followed by asking the client to comment on the dialogue between therapists, and for their own comments on the therapeutic process. This provides a variation of the reflecting process – the focus in on process and not content, the latter being touched on only for the purpose of clarification. Therapists can gain from exploring impasses, periods of discomfort or tension, uncertainty and doubt, or even feelings of failure (Andersen, 1995:27). Clients' comments on what was too unusual, taken out of context and so on may enhance the therapist's own awareness. Andersen (1995:28) believes that clients often appreciate learning what therapists thought about their joint encounter, and for those who left therapy with a sense of it having failed, the "…aftertalk…" provided a sense of repairing which served to enhance dignity and wellbeing.

With regard to his own experience, Andersen (1995:28-30) believes that participation in various reflecting processes has contributed to "…revisiting certain of my own basic assumptions…". Postmodernism is a reaction to the assumptions of modernism which emphasise a hierarchical culture based on objective knowledge regarding how people function, and language as a tool to express thoughts, in the service of information. Alternative assumptions include the view that people are constantly shifting and adapting to different contexts; that people are part of a collectivity with conversations; that language is both "…forming…" and informing (Andersen, 1996:122; 1995:30).

According to Andersen (1996:122), "words are not innocent". The language of pathology or "…deficiency language…" originally developed by professionals has become everyday language and has contributed to a sense of limitation and loss of hope (Gergen in Andersen, 1995:34). Andersen (1995:34-36) wonders what would happen if we, the professionals, started to describe things differently. Much of what we know is based on assumptions, and our questions comprise choices based on which assumptions we find most useful. He poses a question that may be helpful in conversations with

clients: "Is that with which I am occupied the most essential, or is there something else that is more essential?".

Andersen's thinking is compatible with Gergen's social constructionist perspective which is concerned with describing how people explain and account for the world in which they live. It focuses on how common understandings exist and are in the process of creating existence (Biever & Gardner, 1995:48). In addition, therapy is seen as a linguistic activity, whereby the family participates in conversation that creates new meanings and understandings. Michael White's use of reflecting teams, from a narrative perspective, sees the team as witnesses, creating a "…community of concern…" or as Hoyt (1998:108) refers to it, an "…attending community…". Reflections are 'gifts' to the people who inspire them, and add layers to create the thicker descriptions of a person's life.

Reimers (1995:228) explores the view that the use of the reflecting team is less a method of working and "…more a different way of thinking about systems". Not only is it a different way of thinking but also a different way of relating to clients. From a user-friendly position, this author is interested in the descriptions of the method as non-hierarchical, collaborative and respectful. Despite some personal scepticism, Reimers (1995:229) believes the approach to be both creative and "…refreshing…". However, for some families the reflecting team may be too 'different', perhaps even alarming, intimidating or "…plain crazy" (Reimers, 1995:229).

In conclusion, Andersen provides a number of guidelines for reflecting team practice that are consistent with postmodern thinking. These guidelines highlight the importance of generating dialogue, as well as the significance of the self of the therapists (team members) in deciding when and how to respond appropriately or with appropriate difference. The selection of reflections (or not) by the family members may facilitate the change process and create alternative stories.

3.4 ALTERNATIVE STORIES IN USING REFLECTING TEAMS

In keeping with the spirit of the reflecting process, the various alternative ideas explored below are intended to serve as points for consideration, and not prescriptions for what should be done in the reflecting process.

Friedman, Brecher and Mittelmeier (1995:185) explore their own use of the reflecting team in their work with families, which encompasses two mutually interactive processes: a "…widening of the therapeutic lens to incorporate multiple perspectives…" and ideas about the client's problems, together with "…a sharpening of focus…" that channels these ideas into plans for action. This widening of the lens refers to new ideas and narratives, while sharpening the focus brings solutions and steps for action.

Friedman *et al.* (1995:186-192) describe some goals to illustrate the ways in which their reflecting team operates:

- To generate metaphors and images that activate, intrigue and alter the client's understanding of the problem. This includes externalising the problem, an technique of narrative therapy.
- To notice and comment on exceptions to the client's problem-focused view of the self and of others.
- To authenticate change through making comments that embody and entrench the changes in observed behaviour.
- To generate alternative stories (to the problem-saturated, dominant one) that open space for new perspectives.
- To identify and comment on aspects of the self that are hidden, ignored or unnoticed. This goal is in contrast to Andersen's reflecting process – as mentioned before, Andersen believes that the team should not necessarily comment on all that that they observe in the family members, but rather focus on what is spoken of.
- To take a position of humility regarding the complexities of people's lives.

According to Friedman *et al.* (1995:203), perspectives are broadened by the comments of the reflecting team, while the focus is sharpened by the therapist highlighting parts of the dialogue that opens space for the family to review their predicament in alternative ways. The generation of multiple perspectives and the funnelling of these ideas in the post-reflecting team conversation may open up new solutions to the family's dilemma. The reflecting team may activate and mobilise a 'stuck system', while the therapist integrates the threads of the team members with the conversation of the family members. In **not** being attached to a specific outcome, the therapeutic conversation is facilitated so that clients' goals are heard, acknowledged and respected - new possibilities are co-constructed which have more empowering narratives (Friedman *et al.,* 1995:203).

Zimmerman and Dickerson (1996:301-302) set out some of their guidelines for working in a reflecting team from a narrative perspective:

Aspects to consider/pay attention to:

- Contradictions to the problem story – these can be thought of as entry points into alternative meanings and preferred developments.
- Curiosity about developments, how they might become part of the client's lived experience.
- Team members can wonder about the contradictions by using landscape-of-action and landscape-of-consciousness questions, remembering that the family have probably neglected these ideas.
- In asking re-authoring questions, team members are not simply noticing or commenting on the positives – they are helping family members make meaning in response to preferred developments.

How to respond:

- During the reflecting team process, questions may be asked about the noticed preferred developments, reflecting interest in both the occurrence and the history of the problem and contradictions to the problem, as well as the possible future.

- Team members 'situate' each question in terms of how their own personal experience, thinking or viewpoint has informed the question.
- Comments by team members can be responded to by asking what question the comment evokes.

Transparency:

- By situating each question, team members make it clear that their remarks are not necessarily helpful or applicable to the client's perspective – they are simply a team member's own ideas or experience. Situating questions within the experience of the team member may prove meaningful to the family. Such a level of transparency requires, in the opinion of the researcher, self-insight and self-awareness on the part of the team members. Self-disclosure must be appropriate, brief and aimed at benefiting the family.
- Situating a question may include a comment as to why the team member thinks it may be helpful to the family, even though they may not experience it as such.

Reflexivity:

- The reflections of the team are similar to an 'overheard conversation' whereby the family can choose the remarks and questions that have meaning for them.
- The reflecting team can also be thought of as an 'audience' to the family's preferred story.

The narrative approach to family therapy attempts to address the power differential inherent in the therapeutic encounter. According to White (1991:139), the analysis of power is often a difficult concept to entertain because it implies that aspects of our individuality that we assume to be an expression of free will, may not in fact be so. Much of our behaviour is a reflection of our "…collaboration in the control or policing of our own lives, as well as the lives of others…our collusion in …the dominant knowledges of our culture" (White, 1991:139).

White (1991:140) discusses the deconstruction of practices of power, stating that familiar and taken-for-granted assumptions influence peoples' lives and relationships. In externalising conversations about such power practices, we can begin to understand how these may define our lives and the lives of others (client families). In challenging the practices of power we no longer "…subjugate…" the self, our thoughts, beliefs and ways of being, nor do we subjugate our clients through constant evaluation and comparison (White, 1991:141).

According to White (1991:142), the professional disciplines have developed language practices that determine the 'truth' and give an objective and unbiased account of reality and of human nature. Such a perspective reduces the possibility and relevance of other knowledge, and also inhibits critical reflection by the therapist. Therapists can contribute to the deconstruction of expert knowledge by considering themselves as co-authors of alternative practices and knowledge, and creating a context wherein the knowledge of the family is privileged. The researcher is of the opinion however, that some therapists are more at ease with the role of expert and with being the problem identifier and solver. Obviously this way of being impacts on the therapeutic encounter, beliefs about the client family, and choice of intervention.

The questioning of professional expertise and claims to "…extraordinary knowledge in matters of human importance…" has taken several forms (Schon, 1991:5). Some critics attacked professional claims of expertise, while others believed that professionals misappropriated knowledge to protect their own importance and interests in an elite society intent on preserving its dominance. As has been explored in the previous chapter, the postmodern paradigm has challenged the notion of expertise and dominant ideologies that have subjugated people generally and recipients of family therapy specifically.

Cohen *et al.* (1998:290-291) suggest some useful questions in the quest to de-emphasise hierarchy in working with families, both with and without teams, and to aid the enhancement of reflexivity:

- Am I feeling or acting like an expert?
- Are we collaboratively defining the problem based on the person's experience?
- Am I making my work as transparent as possible, by being open and honest about what I am bringing into the encounter?
- Am I checking about ideas instead of assuming them to be correct?
- Am I contributing to the creation of a context wherein everyone involved has a voice in the process?
- Am I inviting discussion about differences?
- Whose language is being privileged in the encounter? Am I trying to understand the person's linguistic descriptions? Am I offering ideas in my language, why, and what effect is this having?
- Am I evaluating this person, or am I inviting him/her to evaluate a range of things, such as how the session is going, preferred directions and so on?

The unmistakably reflexive quality of these questions highlights a need not only for willingness on the part of the family therapy practitioner to consider such aspects, but also to confront the answers that may arise in the asking of them.

Issues of power are paralleled in training/supervision settings where a positivist position emphasises a hierarchical structure (Edwards & Keller, 1995:142). These authors suggest it is a misuse of power to presume that trainees or supervisees do not have the creativity or skills necessary to construct hypotheses or intervene effectively, and quote White who states that such a positivist position emphasises learning of 'correct' methods of evaluation, precision in diagnosis and perfecting specific skills of intervention. According to Edwards and Keller (1995:143), this limits the opportunity for collaborative dialogue, and thus a 'heterarchical' partnership. In the experience and opinion of the researcher, the co-construction of ideas and viewpoints among reflecting team members is such a potentially valuable and enriching learning experience for all team members, regardless of the level of experience, that the move from a hierarchical approach to a partnership is to be embraced.

Edwards and Keller (1995:145) emphasise that heterarchy does not imply equality, but rather that each team member has understandings that the other does not, and has the possibility of promoting a "…partnership discourse…" wherein new meanings are continually evolving. This honours the contributions of all parties, facilitating narratives that have the best fit for the family in therapy. The implications of a partnership in team relations suggests that therapists trained in creative ways are less likely to require "…cookbook…" techniques and strategies to feel equipped to help families in distress (Edwards & Keller, 1995:151).

Lax (1995:145-146) explores the contention that there are times when the team's reflections are **not** useful to the family. These include times when: clients felt that the reflections were confusing and failed to address their issues precisely; the reflections did not give enough direction; the reflections were too long or left them feeling misunderstood by the team. Reflections sometimes had a "…watered-down…" feel about them, even one of phoniness with expressions used by team members such as "struck by" and "touched", followed by overly positive remarks. These issues stimulated Lax to reflect on such experiences, and to pose questions such as:

- What happens when clients/therapists feel that the process has not been useful?
- How is it that clients may feel misunderstood, and could this misunderstanding be useful on occasion?
- How many ideas are too many?
- Is it acceptable for team members to disagree, or even question one another?
- When should new ideas be presented?
- Should team members stay only with what the family presents in the interview?
- What aspects denote 'successful' reflections?

Lax (1995:146) suggests some guidelines to address these questions, and in his review of Andersen's work, realised that Andersen had anticipated many of the issues relating to both the process and content of reflections. Lax (1995:147) outlines some of the views Andersen shared on this issue. Firstly, team members are asked to attend to what is

presented in the interview. If we have prior knowledge of clients (from colleagues, referring agents, and so on) and if this information is not disclosed by the family in the interview, it should not be included in reflections. One way to address this issue is to share with clients what one has been told about them at the start of the interview. Negative perceptions have a pervasive way of permeating the energy in the room.

A further guideline addresses how the reflecting team members talk to one another. Andersen (in Lax, 1995:147) describes how his team moved away from monologues to "…conversations among the team members…", sharing understandings, asking questions of one another, exploring and expanding one another's ideas as well as those jointly developed. Questions may generate more information within the system of participating team members. Lax (1995:148) quotes Madigan who suggests that the team members specifically ask questions of one another during the team dialogue, with the aim of opening up "…new narratives and reflections highlighting…sparkling new events or new domains of inquiry".

Madigan (in Lax, 1995:148) describes how the reflecting process offers the opportunity for the team members to open themselves to change. By omitting themselves from inquiry, reflecting dialogues may give implicit sanction to the idea that the therapists are neutral, more "…together…or are more highly evolved…" than the family specifically and people generally, and know what is best for clients, thus maintaining a hierarchical position in professional work. On the contrary, therapists are part of a context and culture that influences their thinking, and in the questioning process, all participants are enabled to shift from a modern to a postmodern position that values multiple descriptions.

According to Cohen *et al.* (1998:280), questioning and being questioned helps to develop self-reflection regarding where our ideas come from, what our intentions are, our values, biases and so on. This endeavour towards transparent practice is also emphasised by White (1991:145) who suggests that reflecting team members deconstruct dominant discourses as they interview one another about their reflections, and situate these in the context of their personal experience and intentions. The researcher believes that such

transparency may enable team members to become more aware with regard to both self and embodied theory, thus enhancing authenticity in practice.

A further possibility suggested by Madigan (in Lax, 1995:148-149) is that of including the opportunity for clients to ask questions of the team during the interview. Their questions may lead us to the development of new avenues of dialogue that could be explored, or even to asking about team members' own thoughts and feelings, and the impact of the session on them. According to Lax (1995:149), by having clients ask questions of the therapist or team member, several outcomes are possible: the perspective of the therapist can be elucidated; the client's needs and hopes of therapy can be expanded; new directions or narratives can develop. Lax proposes that therapists no longer "…remain shielded by theoretical rhetoric…" that perpetuates hierarchy and the power differential. We are required to examine the process of therapy and "deconstruct" how we practice. This comment resonates in the mind of the researcher – the family therapy practitioner may find it beneficial to deconstruct beliefs about families and the concept of change, the process of counselling, the approach used and the sense of the authenticity of fit between chosen approach and the self.

In the conversation between reflecting team members, the questioning process allows for different understandings to arise and for innovative ideas to be expressed. Comments are situated within what has been observed and personal experience, thus bridging the gap between objectivity and subjectivity. Lax (1995:50) includes the following questions regarding this process:

- What in the interview generated your ideas?
- Was there anything specific that you saw or heard that led you to make these comments?
- Are there any ideas or values you hold that influenced your comments?
- Was there something said that touched you personally?
- Were there any experiences in your life that may have led to these thoughts, and would you be willing to speak about these at this time?

If transparency and equality are valued in the reflecting process and in a co-constructed way of working with families, such questions create more open dialogue. However, Lax (1995:50) echoes a thought that occurred to the researcher – the shift towards greater transparency and accountability to clients may be experienced as intimidating to the therapist and team members. Clearly this does not imply then that transparency should be avoided, but rather that an atmosphere of trust and respect, and a genuine appreciation for the multiple ideas and perspectives of team members contribute to the creation of a context wherein such questions would be less threatening.

In conclusion, the alternative stories of different authors regarding the reflecting team process and the ideas of these authors contribute to the generation of multiple perspectives for contemplation by reflecting team members, providing numerous aspects to reflect on, including questioning the self to enhance reflexivity and authenticity.

3.5 THE REFLECTING TEAM PROCESS IN TRAINING

The shift from modern to postmodern thinking challenges all aspects of counselling, from practice, to research and training (Sexton, 1997:12). Training in traditional family therapy models is based on the epistemology of the trainer and the relationship between trainer and trainee tends to be hierarchical. Live supervision with extensive pre- and post-session discussions aim to explore ways of working with families and understanding them within the framework of the relevant paradigm (Hanford, 2004:48-49). While this comment is relevant, it is not strictly true of family therapy training at Family Life Centre. Because family therapy practitioners come from diverse academic backgrounds, their particular paradigm is respected, albeit within the context of a training setting that leans toward postmodernism.

According to White (1990:76), the expectations of those involved in training and/or supervision are very significant. Such expectations are closely related to the beliefs held by both parties concerning the nature of the therapeutic encounter and training/supervision. White (1990:76-77) goes on to state that a positivist view implies

objectivity, expert analysis and intervention aimed at getting to the core of the problem. Hence, training and supervision that is informed by this premise would emphasise 'correct' methods of evaluation, diagnosis and intervention, using known skills and techniques. If there is a match concerning the expectations of participants, a degree of comfort in the encounter will be achieved. However, such a match does not always occur and may result in conflict with resolution slanted in favour of the trainer or supervisor. White (1990:77) emphasises the importance of trainees being provided with knowledge about the ideas and practices that are embraced at the particular organisation where training will be undertaken, and on the nature and structure of the training context.

As previously mentioned, at Family Life Centre practice is eclectic in that family therapy practitioners come from diverse educational and theoretical backgrounds. While no approach is given particular precedence, the influence of the postmodern epistemological shift is evident. The reflecting team format, as advocated by Tom Andersen is used in order to provide an experience of family therapy that is egalitarian from the perspective of both recipients and practitioners. Although training is an important focus at the Centre, it is not a way of imposing a particular approach upon trainees, but rather facilitating a learning process that allows practitioners to experience the family therapy process in different ways according to which therapist is conducting the session. An advantage of this is the opportunity to view different theories in action, and perhaps to enhance awareness of theoretical fit with the self of the therapist. The actual reflecting process however, is conducted according to Andersen's guidelines.

According to Worden (1999:53), new family therapists often begin their careers as purists, following the model or approach they were exposed to in academic training. With experience however, there is a trend towards eclecticism and amalgamating theory, experience, personality and personal preference. Carlson and Erickson (2001:200) believe there exists little in the literature that addresses the training of new therapists with regard to postmodern ideas, and that this lack of literature suggests that although these ideas are influential, they do not apply to new therapists. On the contrary, these authors propose that postmodern thinking offers enormous potential for the training of new

therapists, specifically narrative ideas which recognise and honour more personal and local knowledges and skills. Such a viewpoint emphasises the 'person' of the therapist whereby theories and practices are embodied and incorporated into the stories of their own lives (Carlson & Erickson, 2001:201). This theme will be expanded further in Chapter 4.

Hoyt (1998:3) describes certain characteristics of the constructivist therapist, while Biever and Gardner (1995:48-49) attempt to integrate social constructionist thinking into the practice and supervision of family therapy. These authors suggest the following ideas which have value in a training setting:

- Meanings are developed through social interactions and consensus – thus there are many possible understandings, descriptions and conversations that may be helpful to families. All ideas are potentially useful. The therapist believes in a socially constructed reality.
- All understandings are negotiated and embedded in a context, thus knowledge is cooperative and active. The therapeutic relationship is reflexive in nature as meanings are constructed through dialogue.
- There is a move away from hierarchical positions towards an egalitarian one which emphasises differences and numerous ideas. The client is the expert on their problem or dilemma, thus goals are co-constructed.
- Client competencies, strengths and resources are actively searched for, while deficit or pathologising perspectives are avoided.
- Problems evolve in the context of the narratives people tell themselves about their lives – narratives and meanings are always changing in relation to the social context in which they developed. Ignored, suppressed or unacknowledged voices and stories can be liberated through the use of empathy and respect for the client.
- Narratives and meanings can be expanded; therefore we can expand possibilities within the context of social, political, economic and cultural constraints.

Biever and Gardner (1995:49) pose the question of how one trains people within a model that suggests knowledge is negotiable. Just as different families will respond in different ways to the same therapist, trainees will develop different understandings of a family and of the supervision process. According to these authors, strategically orientated family therapy is not appropriate to family therapy from a social constructionist model which evolved from collaborative and linguistic approaches. Traditional family therapy teams engaged in a process of evaluating and eliminating some ideas, rather than generating a variety of ideas. The use of the reflecting team in a training setting is a way to minimise the contradictions inherent in the different models, and is consistent with social constructionist thinking. The researcher concurs with this view, having experienced at first hand many of the different approaches in action. While both a purist and an eclectic position are respected within the team, it is apparent that multiple perspectives and ideas often have value for client families. On the other hand it could be argued that this confuses the picture for those team members who favour a purist model, that different ideas and viewpoints 'dilute' the impact of a particular approach to family intervention. Developing a reflexive attitude to therapeutic work is essential if one is challenged to resolve a potential professional dilemma.

The idea of multiple explanations and descriptions is easily understood by trainees, however according to Biever and Gardner (1995:49) there remains a tendency to either/or thinking or the search for the 'right' or 'best' idea. The process of reflecting team work illustrates the difference in meanings that people generate through dialogue. Team members can discuss their interpretations of the family's comments, and how they would describe the situations explored in the session. Following the team's feedback to the family, team members have the opportunity to listen to the family's reaction to the discussion – new meanings may be generated for team members as well as for the family (Biever & Gardner, 1995:50).

The belief that all ideas are potentially useful is pertinent in reflecting teams, as the process encourages the sharing of ideas, regardless of level of experience. The family 'chooses' the ideas that fit for them, thus lessening the over-ruling of certain ideas by

supervisors, which may have had meaning for the family. Trainees thus feel freer to express their ideas, even if they differ from other team members. The reflecting team allows for fuller participation by all people in the therapeutic process and according to Biever and Gardner (1995:50) develops confidence in the ability to use language and conversation therapeutically. In addition, these authors suggest that the transition from member of the reflecting team to in-the-room therapist is less stressful for practitioners who have had the opportunity to interact in the team discussions. According to Hanford (2004:53), participation in a reflecting team allows trainees to enter the observing system gradually, since there is no pressure on them to participate until ready to do so. There is less feeling of having to 'get it right' since multiple descriptions are sought, and trainees may be less concerned with defending their position and thus more open to learning from both their own contribution and that of fellow team members.

Whilst the researcher is in agreement with these statements, it must also be realised that trainers of family therapy would need to be at ease and comfortable with such a heterarchical position in the team, believe in the relevance of socially constructed meanings, and be able to facilitate a team climate that allows difference to be expressed.

In her research on therapist development in a reflecting team setting, Hanford (2004:51) explores the influence of second-order cybernetics on training, stating that less time is spent on teaching, and more on being curious about the trainee and her experiences. Trainers take a 'not knowing', non-expert stance, recognising that there are multiple perspectives and alternative ways of being. Trainer and trainee co-construct understanding, with all ideas being reflected on and valued, thus challenging the issues of power, control and hierarchy. According to Sexton (1997:13), training becomes a process of creating experiences, and developing and sharing meaning systems as learning is "…embedded within social discussion and reflection". Rather than learning and copying the meanings of the 'teacher', the focus is on developing dialogue and expanding understanding of therapeutic events. White (1990:85) believes that attempts to 'copy' the style of the trainer or other reflecting team participants is doomed to failure, and that it is

the uniqueness and originality of the therapist that is most likely to facilitate growth in the family therapy context.

In the experience of the researcher, trainees are aware of their feeling of insecurity and uncertainty, and value the opportunity to observe fellow family therapists in action. However, they may also feel that they are being compared, which may exacerbate anxiety with regard to being the primary therapist (i.e. the therapist conducting the session).

Training settings that encourage a didactic, hierarchical approach value expert knowledge over personal experience, knowledge and skill. Carlson and Erickson (2001:202) believe this excludes and disqualifies alternatives and results in practice that encourages therapists to "…forget the very personal nature…of our work and lives as therapists, and as persons". The concern of these authors is that this invites "…unhealthy self-doubt…" for the new therapist, and feelings of despair and incompetence.

Du Toit (2002:34) explores the phenomenon of experiential learning in the context of training (although not specifically in family therapy) and suggests that a postmodern approach which focuses on understanding as central to experiential learning is more applicable and accessible in training situations, and is preferable to the didactic acquisition of skills that come with a modernist flavour of objectivity and 'correctness'.

With regard to the question of training in the reflecting team process, Biever and Gardner (1995:51) suggest some modifications to the guidelines proposed by Andersen. These modifications are seen as necessary, since the reflecting team is heterarchical, while training is inherently hierarchical. It is suggested that the 'no talking behind the mirror' rule may be too restrictive in training settings – the supervisor may wish to call attention to the skilled use of questioning, or suggest a possible alternative direction the therapist may have taken at a particular point in the interview. In addition, trainees may want to ask brief questions if they are confused or need clarification. Such conversations need not be harmful to the reflecting team process, and may even generate new ideas which can be shared with the family during the team discussion. Preparation for participation in

the reflecting team discussion tends to limit the use of negative or critical remarks by team members.

Andersen (in Biever & Gardner, 1995:51) recommended a veto on any discussion about the family outside of their presence, thus eliminating any pre- and post-session dialogue. However Biever and Gardner (1995:51) believe these to be necessary in the context of training, as too is the retention of the phone-in message, used on occasion to facilitate the therapeutic process. Consistent with social constructionist thinking is the prohibition of negative comments, normative judgment or diagnostic labelling within the reflecting team process. However, trainees may become so focused on such prohibitions that the flow of ideas is constricted and according to Biever and Gardner (1995:52) even without an explicit ban, such comments are rare, due to the focus on alternative descriptions and explanations. Negative comments made by a team member in the reflecting team discussion can be included as a possible description or explanation, and may even open up space for the family to express their own negative evaluations or realise that there are alternatives to such evaluations. Occasionally, comments that do not seem negative to the team may cause a reaction from one or some of the family members – the therapist can ask for clarification from the person, or even from the team member.

Biever and Gardner (1995:52-54) set out some guidelines for the use of reflecting teams specifically within a training setting, which may differ slightly from other accounts of reflecting team practice (discussed above). Their guidelines are as follows:

- Introducing the idea of the reflecting team – this type of approach requires early introduction to client families during the initial discussion around understanding of the therapeutic process. Clients are given a choice as to whether or not the ideas of the reflecting team are listened to.
- Behaviour behind the mirror – team members can reflect on two questions: How else can this situation be described? How else can this be explained? In addition, team members should listen for strengths and potential solutions. Discussion behind the mirror should be limited to questions and comments regarding the process of therapy.

Comments about the family should be held over until the reflecting team discussion. Questions should only be asked when there is confusion about the content or process of the session.

- The reflecting team discussion – comments during the discussion should be based on information derived from the session and referenced to comments/events from the session. All ideas must be presented respectfully and tentatively, remembering that the goal is to open dialogue regarding alternative descriptions and explanations. Consensus among team members is not necessary – a variety of ideas are useful for clients to choose from. The time allotted for the reflecting team discussion is brief (5 to 10 minutes), therefore it is not possible to discuss all ideas fully. Too much information will not be absorbed by the family – often a few short remarks with dialogue among the team members is more useful to the family. Diagnostic, evaluative and normative labelling should be avoided, as these may constrict the creation of new possibilities. Family labelling of their own behaviour may be challenged by presenting other possibilities. The discussion should be positive and hopeful but it is not necessary to reframe every situation as this may leave the family feeling that their problems were not taken seriously. Compliments need to genuine and specific, avoiding clichés. Homework assignments are not routinely given although suggestions for tasks may be made, and presented as tentative ideas.
- Post-reflecting team family/therapist dialogue – this is an opportunity for the family and therapist to discuss their reactions and understandings of the reflecting team discussion. The therapist can ask a variety of questions: Did you have any thoughts or ideas while listening which made sense to you? Was there anything you disagreed with? Was there anything you thought should have been included? Therapists may also explore the family's interpretations of the team's comments. If a comment was taken as criticism, the team can phone through to clarify, or even have another reflecting team discussion. Often the conversation following the reflecting team discussion will appear to have no connection to anything said in the discussion – in such a case the therapist should follow the family's lead. Lax (1995:162) suggests that reflections be related to all family members in the session and that which has **not** been commented on by team members is as important as what is. In addition, the

therapist is often left out of comments during the reflecting process, yet is part of the conversing system. Commenting on avenues the therapist did not explore allows for other topics to be commented on, or at least introduced.

The guidelines and observations outlined above are of interest to the researcher, since they correspond closely to the way in which the family therapy teams operate at Family Life Centre. In addition, the observations resonate in the mind of the researcher, in terms of how families often respond to the reflecting team in the day-to-day reality that is family therapy.

Biever and Gardner (1995:55) suggest that while the use of reflecting teams is valuable in training, they are not sufficient to meet all the training needs of trainees. These authors suggest both group and individual supervision complement the experience of participation in the reflecting team, through focusing on learning and experience. In conclusion, Biever and Gardner (1995:55) suggest that the reflecting team process is beneficial to both trainees and to the more experienced family therapy practitioner and that through the growth of this method of working with families the potential of reflecting teams can be realised.

Thus it may be seen that training in a reflecting team setting is a move away from the traditional family therapy team training that emphasised a particular paradigm and a hierarchical method of teaching.

3.5.1 Possible Disadvantages of the Reflecting Team in Training Settings

According to Young, Perlesz, Paterson, O'Hanlon, Newbold, Chaplin and Bridge (1989:73-74), the evolution of the reflecting training team is consistent with second-order cybernetic and systemic principles. The reflecting team is viewed as congruent with the basic principles of systemic family therapy, i.e. that the observer is part of the observed system, and the family participate in their own therapy as "…observers of the observers". The recursive nature of the therapeutic process is reflected in the relationship between

trainer and trainees. All team members have a view of what happens in the session and identify with different parts of the system – they affect, and in turn are affected by the team discussion, which in turn can be affected by the family, thus a co-evolutionary process ensues.

However, Young *et al.* (1989:71) suggest that there are some difficulties inherent in the use of teams in a training setting. Knowing that a team of colleagues, as well as a supervisor, are observing from behind a one-way mirror may be potentially disempowering for a trainee family therapist. There may be high levels of performance anxiety which, according to these authors is more prevalent in female trainees, as well as constraining beliefs about doing things 'right' that may impact on the acquisition of both cognitive and executive skills.

These authors go on to suggest that a disempowered therapist may find it difficult to empower the family, even disempowering them further in a struggle to impress colleagues and supervisor (Young *et al.,* 1989:72). The use of a reflecting team addresses these issues and may enhance the 'power' of trainees within the training process. Performance anxiety is shared within the system, as trainees and experienced therapists contribute to the discussion as the family watches. All participants see team members struggling to make sense of the interaction between therapist and family members, which may enhance the gaining of a meta-perspective more readily. Responsibility is spread more evenly amongst reflecting team members, and the team context may be more creatively empowering, engendering via a parallel process, a more empowering environment for the family. Team members are more likely to remain engaged with the process, knowing that they will have to participate actively in the reflecting team discussion. Since a variety of alternatives are sought, the 'right' perspective is not the most important issue. According to Young *et al.* (1989:72), the style of dialogue in reflecting processes (i.e. positive connotation, speculative, tentative) is more congruent with patterns of female socialisation, thus giving female trainees a forum for open expression.

Potential disadvantages of the use of the reflecting team converge around collective responsibility. Does the reflecting team become responsible for the outcome of therapy? Does the therapist feel a sense of losing control of the process and content of the therapeutic encounter (Young *et al.,* 1989:72)? For the researcher, such aspects require discussion and exploration within the team – in making such issues explicit and open for dialogue, reflecting team members may feel less anxious and more empowered.

According to Biever and Gardner (1995:47), the transition from theory to practice is often difficult, especially when there is a contradiction between theory and the process of training and supervision. The use of the reflecting team is a way of surmounting such a dilemma, since there are multiple explanations of a problem, the generation of ideas through dialogue, and validation of notions of what is deemed useful. This view is pertinent to the practice of family therapy at Family Life Centre, where team member's academic backgrounds and experience of supervision may differ from that conducted at the Centre. The fact that the team is made up of individuals with various theoretical orientations may enrich the feedback provided during the reflecting process. Comparisons of views, perspectives and meanings may enhance awareness, create alternative meanings and open the door to a new story. In addition, team members gain insight into other possibilities and viewpoints, gleaned from fellow members.

Therefore despite a number of possible problematic issues relating to the reflecting process in training settings, the potential for professional and personal growth for the trainee (and experienced family therapist) is evident. The value of dialogue and the exploration of multiple perspectives provide an enriched learning opportunity for reflecting team members.

3.6 PEER REFLECTING TEAMS

Various authors discuss the use of peer reflecting teams (also referred to as audiences or outsider witness groups) (Morgan, 2000:121; Selekman, 1995:206). In narrative therapy, the therapist may create processes in which people act as witnesses to the conversations

between family and therapist. Outsider witness groups may be other therapists, family members, friends, members of the community or people unknown to the family. Morgan (2000:122) states that the conversation of the outsider witness group is guided by the principles, ethics and practices of narrative therapy. Dialogue is around aspects that caught the attention of group members, things they were curious about, comments on events and so on. Speculations are undertaken with the utmost hesitancy and respect, without a presumption of knowing what is right for the family. The group members may recognise similar experiences and reflect on how these may resonate for the family, thus 'thickening' the alternative stories. **De-centred** sharing involves linking stories of the lives of the group members with stories of the lives of the family – this is done in such a way that the family remains the focus (Morgan, 2000:124).

The family are given an opportunity to respond and comment on the dialogue of the outsider witness group, and invited by the therapist to speak about the experience. In this way, Morgan (2000:125) believes the group becomes more accountable to the family for the real effects of what has been said, and learns what has been most helpful (or least helpful) to them.

Developmental theory stresses the importance of peer relationships in adolescence, wherein identity is formed, social skills are developed, personal values are established and generational boundaries are demarcated. Selekman (1995:207) believes that the significance of the peer group in the adolescent life stage has not been advantageously utilised in family therapy, and can be a valuable resource in working with families with adolescents. According to the experience of Selekman (1995:207-210), in his work with families with adolescents, there are five ways in which peer reflecting groups can be utilised that contribute to change, empower a stuck process and elicit creative and pragmatic ideas in a collaborative encounter. These are:

- Peers may be facilitators of trust – often adolescents and parents mistrust one another and peers may be helpful in rebuilding trust by enabling parents to meet their child's peer group, often for the first time, understand their activities, problem-solving efforts

and so on. Parents may gain awareness and insight into their adolescent's lifestyle that they may have pre-judged or misunderstood.

- Peers may be a support system for relapse prevention – adolescents often resist self-help groups (e.g. Alateen) aimed at relapse prevention. Peer group members who have succeeded in overcoming their own chemical dependency issues can be a useful resource in helping an adolescent stay 'clean' and often have many creative ideas about how to achieve this, as well as providing support in difficult times.
- Peers as members of a solution-developing or solution-construction system – participation and collaboration in finding solutions may be sought from peers who have provided support for problems in the past, or who have experienced success in resolving similar difficulties.
- Peers as observers of noteworthy change – within the context of family therapy, the experience of hearing about changes in the life of an adolescent from his/her peer group may be helpful for families to begin a new construction of the family situation, challenge previously held beliefs and pave the way for creative solutions.

Including peers in family therapy sessions requires consideration of a number of factors: the therapist must determine the purpose for enlisting peers as consultants; exploration of the family's receptiveness to this type of interventions; obtaining permission from the parents of peer participants and explaining the rationale for his/her inclusion (Selekman, 1995:211). Selekman (1995: 218) believes that peers may be instrumental in the solution-construction process, and creative and pragmatic in developing coping strategies.

With regard to ethics and confidentiality, Lobovits, Maisel and Freeman (1995:224) suggest that family therapy practice in a more public arena (i.e. peer reflecting teams, outsider witness groups) challenges the traditional view of therapy in a private and protected environment. These authors believe that the need for privacy increases when people and problems are viewed in terms of illness and pathology, or other problem-saturated descriptions. Narratives that evolve around preferred ways of being tend to

reflect well on people and their goals, and have less need to be protected from more public exposure.

Lobovits *et al.* (1995:224) make the distinction between different types of audiences. The 'known' audience refers to those people in a person's life "…who interact with, and influence his or her unfolding story". These people (relatives, friends, teachers, significant persons) may be drawn on to witness change, a preferred story, and perhaps also to participate in the creation of such a preferred story. According to Lobovits *et al.* (1995:225), known audiences may be sympathetic and involved in creating positive meaning with clients – they may also be sceptical and need to be recruited into the reconstruction of meaning.

The second audience is the 'introduced' audience who are drawn from the wider community of those who have struggled with a problem, who understand its social context and who are successfully dealing with the problem (Lobovits *et al.,* 1995:225). Such audiences appreciate the need for alternative stories, may offer local knowledge of resources, skills and techniques to help change the problem-saturated story. Recruitment involves requests for families to contribute to what they have learned about solutions to a problem, or groups who may video or mail interactions for the family to share.

The benefits of using audiences in family therapy are reported as feelings of satisfaction at making a contribution to others in need, feeling valued as a survivor and having the opportunity to participate in someone's life in a positive way. There are however, potential risks involved in recruiting or evoking audiences. Lobovits *et al.* (1995:234) suggest that audiences have the power to promote or impose narratives and prescriptions that "…impoverish and oppress...". A belief in the competencies and knowledge of client families is essential, and once identified, these can be documented and shared with others experiencing similar problems. Enthusiasm for this way of working should not prevent a full exploration of any reservations clients may have. Compliance is not agreement, and clients may want to please the therapist or feel uncomfortable with refusing. This may require specific questions to allow clients to carefully consider the effects (positive and

negative) of using an audience. Informed consent requires full comprehension of the implications of intervention, and must be voluntary and without any coercion.

Lobovits *et al.* (1995:236) suggest the "… revisioning…" of the boundaries of the therapeutic relationship and quote Waldegrave who states that the helping professions are the emotional barometers of pain in their communities, and thus have a moral obligation to be informed about broader social, political, economic, cultural and gender issues. Such knowledge should be shared in an effort to influence social policy. The development of therapeutic practices that diminish the negative effects of social and cultural hierarchies is a goal of reflecting team work, and the validation of every family member's opinion, right to speak, diversity of viewpoint and so on, facilitates a both/and solution instead of reinforcing power differentials. Lobovits *et al.* (1995:238) also suggest that we concern ourselves with the issue of accountability. Our life experiences, social class, gender, race, as well as our professional socialisation influence the therapeutic encounter. We need to be willing to stand corrected, and an audience may serve as a "…cultural consultant…" in creating awareness of non-dominant groups, beliefs and values.

In conclusion, the use of peer reflecting teams may provide unexpected solutions to a range of problems and give social support for change. The therapist is no longer the sole source of support and knowledge for the family, and the therapeutic process is enriched with creative ideas and solutions.

3.7 TRAINING IN REFLECTIVE THINKING

Peterson (1995:979) quotes Schon who poses the question of how we know what we know and whether such knowledge comes from textbooks? Schon believes that knowing is built on experience. The process of reflective thinking involves grappling with problems and engaging in a continuing process of reflection as we engage in practice.

Hanford (2004:47) explores aspects related to counsellor training and education, and quotes Griffith and Frieden who define reflective thinking as a process of continual examination of the therapeutic journey in increasing levels of complexity and evaluation. In reflecting team practice, trainees learn through observation of the observations of others – in other words, the trainee becomes part of the observing system. As defined in Chapter 1 (point 10.3) reflective thinking is an aspect of reflexivity, both of which are essential to assist the trainee, or any therapist for that matter, to challenge the ways in which he/she is thinking about the self, as well as the client family.

Zimmerman and Dickerson (1996:115) suggest that reflexive thinking allows people to wonder about multiple possibilities for understanding experiences. These authors describe several ways to create a reflexive position in a therapeutic context, which include: curiosity about what is occurring in the therapy room; taking a break so that both therapist and family can have some thinking time; constructing an end of session summary. Most helpful is the use of the reflecting team to interview one another, raising questions about aspects relating to the interview. According to Zimmerman and Dickerson (1996:115), this creates space for team members to make new associations, be curious, offer their own experiences as a basis for the origin of the question (i.e. situate the question) and co-construct preferred outcomes with the client family.

Hanford (2004:48) suggests Socratic questioning, a form of critical thinking whereby the trainee is encouraged to reflect on his/her existing knowledge, as well as on insecurities and inadequacies. The trainee is helped in this process to gain awareness of how such thoughts impact on the therapeutic process. Another technique that may be helpful in the journey towards self-awareness is journaling, wherein the trainee can explore beliefs, assumptions, values and experiences in a personal context rather than within the team. The researcher, while concurring with the value of journaling in terms of self-exploration, believes that discussion within a group context that is supportive and non-threatening, yet challenging, can be facilitative of both personal and professional growth.

In the experience of the researcher, participation in the reflecting team process creates an exceptional learning environment that provides the opportunity to learn from fellow team members in ways that may challenge our assumptions about knowledge and facilitate the journey towards a more reflexive position.

3.8 SUMMARY

Reflecting team practice may facilitate an atmosphere of growth and self-awareness, necessary to enhance understanding of the impact of the self on intervention with families. The egalitarian nature of relationships between team members is conducive to learning and to finding a voice, even a different voice, and developing the confidence to express it.

This chapter explored the use of reflecting teams in family therapy, beginning with a discussion of the concepts of monological and dialogical conversation as a way of situating the importance of generating dialogue in therapeutic change. The reflecting processes of Tom Andersen were explored, with reference to his personal paradigm shift from traditional family therapy team work to a heterarchical position that aims for equality and democracy between therapist, team members and family members.

Various guidelines for practice, from the perspective of Andersen, were illuminated which highlight the importance of generating dialogue in reflecting team processes, and emphasise the significance of self-awareness for reflecting team members and, similarly for the family therapist in therapeutic interaction with the family.

The views of a number of authors on reflecting team work were examined in the hope of providing a comprehensive picture of the numerous ways in which reflecting teams may operate, as well as an exploration of the possibility that reflecting teams may not always be helpful to families, and the process may engender various issues that require consideration. The reflecting team process in training settings received attention, as well as certain obstacles or disadvantages that may be relevant to the training environment.

The use of peer reflecting teams, or outsider witness groups, was touched upon as a way of stimulating thinking around creative ways of working with families. The generation of unexpected solutions or ideas from people who may be part of the social fabric of the lives of family members may prove invaluable. Finally, the process of reflective thinking was briefly explored, with some ideas about how this significant aspect of professional development could be enhanced.

In the final chapter of the literature review, the development and use of the self in family therapy and the personal embodiment of theory will be explored.

CHAPTER 4

THE DEVELOPMENT AND USE OF THE SELF IN FAMILY THERAPY

4.1 INTRODUCTION

Family therapists have endorsed the position that supports the shift from a study of the 'observed' system to the study of the 'observing' system. Thus, according to Haber (1990:376), it would be futile to look at the family system without considering the contribution of the therapist to the 'fit' of the family system. Positions of both neutrality (if such is possible) and involvement with the family system impact on the reactions and perspectives of the client family in the therapeutic relationship. Baldwin M (1987:7) believes that with the development of new forms of therapy and technique, it is essential to explore more fully the role of the self of the therapist. Since the self has the potential for both positive and negative impact upon the client, the importance of personal self-knowledge and self-discipline is crucial.

The implications of a belief in the significance of the self of the therapist in the therapeutic encounter suggests that if the self is viewed as a resource, then it is incumbent upon both therapists and the organisations that employ them to maintain and care for the self. While there are many satisfactions relating to therapeutic work there are a number of identified consequences of the toll taken by such work. Berger (1995:304) explores some aspects of the negative impact of the helping professions on the personal lives of therapists. These include difficulties with family, friendships, and social functioning as well as incidences of depression and an increase in suicide risk. If we accept the importance of the self in the therapeutic encounter, self-awareness and care of the self is crucial to being authentic and reflexive in practice.

In this the final chapter of the literature review, the concept of the self on a personal level, as well as within the context of the therapeutic encounter will be explored. McGoldrick and Carter (2005:34) refer to the connected self which is based on the interdependence of people and psychological health, and these aspects will be considered, together with the views of Frankl (in Durston, 2005a) on optimal human development.

The path to becoming a therapist, and specifically a family therapist, is deeply personal and idiosyncratic. A number of authors share their personal journey relating to this undertaking, aspects of which may resonate with the reader and perhaps evoke an enhanced awareness of one's own motivations for choosing a career in the helping professions. The development of the personal and professional self is a continuous process of reflexivity that is unique and specific to every practitioner of family therapy. It is not the intention of the researcher to suggest a path to follow on this journey, merely to illuminate its complexity and highlight the necessity of undertaking the task.

While theory is an essential aspect of family therapy practice it is not the primary force in the therapeutic encounter. The discovery of a theory (or theories) that is (are) congruent with the self of the therapist is essential to the development of a therapeutic style that enhances the authenticity of the practitioner and hence the therapeutic relationship. The importance of knowing one's personal paradigm is highlighted in this discussion, as well as the need to reflect on our assumptions and knowledge so as to avoid what Amundson, Stewart and Valentine (1993:111) refer to as the dual temptations of power and certainty in therapeutic practice.

Experiential aspects relating to becoming a family therapist will be briefly explored, after which the importance of the therapeutic relationship will be considered, including a brief discussion on the dangers of certain aspects of the therapeutic relationship and therapeutic practice which may impact upon the self of the therapist and on the broader context of personal life. Evaluation of the role and practice of the therapist is imperative and these issues will be examined with some recommendations on the promotion of

"user-friendly practice" which considers the experience of the therapeutic encounter from the vantage point of the client (Treacher, 1995:197).

Enhancing self-awareness and reflexivity remains an important task for the family therapist, and certain literature is explored that may facilitate this process. Aspects include the explorations of one's own 'story' in relation to the client family and visualisation of real and/or imagined extra-therapeutic encounters as a tool to enhance awareness of responses to clients. Finally, the issue of burnout will be discussed, related to aspects such as awareness and prevention that may sustain the self of the therapist over the career span.

4.2 DEVELOPING A SELF

According to Baldwin D (1987:28-29), the nature of the self has provoked curiosity throughout the ages, with the ancients viewing it as the essence of man and implicit in the concept of the soul. Cartesian thinking emphasised the objective side of life over the subjective, and it was not until the philosophers such as Kierkegaard, writers such as Dostoevsky and clinicians such as Freud and Jung that the subjective world began to be explored. Kierkegaard and the existential philosophers drew attention to the idea of the subjective experience of the human being, as well as being both subject and object, and thus the concept of the self emerged. The concept of self excited the interest of sociologists such as George Mead, philosophers such as Heidegger and therapists such as Carl Rogers. Thus the development of the concept of self reflects a kind of parallel with the modernist/postmodernist evolution, an epistemological shift, similar to that of the theory and practice of family therapy.

According to Baldwin D (1987:30-31), Mead introduced the concept of the self as a basic unit of the personality, along with the roles which the self learns in the process of socialisation. Developmental thinkers such as Erikson described the emerging self in terms of the ego development and psychosexual development of the child, with the concept of identity as the awareness of difference and separateness of the self. Rogers

viewed the self as a fluid structure, subject to change throughout life – the self is a "…constellation of perceptions and experiences, together with the values attached to those perceptions and experiences" (Merry, 2002:33). According to Baldwin D (1987:31), contemporary views of the self suggest that there are different aspects of the self which are available to a person, depending on the circumstances in which one finds oneself.

Satir (1987:17) was of the opinion that the therapist who came to view the self as an essential aspect of the therapeutic process was the "…herald of that new consciousness". The influence of Martin Buber's views centred on the **I-thou relationship** with fellow human beings, wherein the "…world of relation…" is established (Buber in Baldwin D, 1987:33). This involves a sense of, and appreciation for, the subject and object of each person in a relationship that is characterised by "…mutuality, directness, presentness, intensity and ineffability" (Friedman in Baldwin D, 1987:33).

In contrast, the **I-it relationship** is one of subject-object, where others are regarded as mere tools or conveniences, and this subject-object approach is the medium of exchange in the world of things and ideas. The I-it relationship typifies many human interactions, even healer-client ones, and according to Miller and Baldwin (1987:148), this type of interaction is essentially superficial and meaningless. The I-thou relationship is one of reciprocity and for Buber, is the highest expression in the act of confirming the other – mutual confirmation is seen as the key aspect of the definition of the true, real, present and authentic self (Baldwin D, 1987:34; Miller & Baldwin, 1987:148). Miller and Baldwin (1987:148) suggest that when a healer or therapist relates openly and totally with a client, the I-thou relationship facilitates wholeness in both client and healer, and that through awareness of the self, the therapist finds the source of his/her own vulnerability.

The work of Emmanual Levinas takes the concepts of Buber further, basing the self/other relationship on ethics, a respect for the **Other**, as opposed to the **other** who is knowable

according to positivism. The Other is unknowable, beyond language and outside the purview and control of the self (Levinas, 1991:17).

With regard to the idea of the self in the therapeutic encounter, Shadley (1987:127) refers to a definition of the self as the therapist's "…feeling response to the family members". The felt self is one aspect of the process, together with verbal and non-verbal responses, and appropriate self-disclosure. A definitive description of the use of self in therapy is elusive because of the individual, unique nature of the therapist. However, according to Shadley (1987:128), it encompasses not only professional expertise, but a level of self-awareness that provides clarity regarding which parts of the self to withhold in order to preserve strength, health and integrity. This requires a consideration of various factors such as personality, personal and professional experiences, theoretical orientation and interpersonal context. The implication of this is the necessity of knowing the self in all of the contexts of the therapist's life, and according to McGoldrick and Carter (2005:27-28), maturity is defined as the "…self in context…" which refers to our ability to live in relation to others and the world, to be able to control our impulses, and to think and function for ourselves based on a personal belief and value system that is not contingent on general consensus. It involves too, an ability to empathise, communicate, collaborate and respect the views of those who are different, and interact with our environment in ways that are not exploitative. McGoldrick and Carter (2005:27) expand on the conceptualisation of human development to include a view of the self that integrates race, class, gender and culture as central to individual development.

According to this perspective, gender, class, race and culture form a basic structure around which beliefs, values, emotional expression and ways of relating to others are built. Thus the world view of every person and generation differs since this structure evolves over time (McGoldrick & Carter, 2005:28). This structure significantly influences the parameters of an individual's ability to empathise, communicate and connect with others. If this is so, the researcher speculates that the personal self, and hence the professional self, are profoundly affected by the unique structure that forms the foundation of that individual self.

McGoldrick and Carter (2005:28) believe the most challenging aspect of the development of the self to be one's beliefs about, and interactions with, people who are different from ourselves. Baldwin M (1987:7) concurs, stating that ideas about the self are connected with our emotions and belief systems rather than our intellect, and thus we react strongly to views which differ from our own. Society is quick to assign roles and expectations based on gender, class, race and culture which influence the acquisition of various skills, such as communication, cognition, emotional and social skills. According to Baldwin M (1987:7), the entity of the self is personal and elusive, changing in nature from being the subject to the object of observation. It can never be known in its entirety, since others will never have complete knowledge of our inner experience and we are not aware of some manifestations of our self that are easily perceived by others.

McGoldrick and Carter (2005:28-29) state that the development of a mature, independent self requires an appreciation of our interdependence on each other and on nature, and involves the following skills: the ability to feel safe with both the familiar and the unfamiliar or different; the ability to read emotion, empathise, care for and be cared for; the ability to accept one's self while accepting differences in others, and to relate to others with a generosity that does not depend on their approval or support; and, the ability to consider others and future generations within the context of human and environmental rights. The relevance of these skills in the practice of family therapy is evident.

Thus, the self develops around a structure that contains many variables which interact with one's unique person and environment. The researcher believes that this has clear implications for the development of the personal self and hence, the professional self, impacting on the way in which the client family is viewed as well as on the intervention approach embodied by the individual family therapist.

4.2.1 The Connected Self

According to McGoldrick and Carter (2005:34), the "…connected self…" is based on recognition of the interdependence of people and is seen as critical to the development of

psychological health. Laing (in Baldwin D, 1987:39) concerns himself with the issue of confirming the self, which requires the existence and recognition of the self by another, a view which shares similarity with that of Buber (discussed above). These views focus attention on the interdependence between people in relation to the self, and on the fundamental importance of affirmation of the self to become more real and authentic. Mature human interdependence includes the following skills (McGoldrick & Carter, 2005:34-35):

- Participation in cooperative activities (i.e. at work, home and play).
- Expression of a full range of emotions and tolerance of such emotions in others.
- Expression of differences of belief or opinion without attack or defence.
- Relating with openness, curiosity, tolerance and respect to people who differ from ourselves.
- Nurturing, caring and mentoring of others.
- Accepting the help and mentoring of others.

It can be surmised from the above that the skills deemed necessary for maturity and interdependence are aspects that are immensely relevant to the context of both family therapy and reflecting team practice. The need to participate, express oneself without fear of attack, yet being able to be true to one's self, being able to relate to others, be it team members or client families, and being able to accept and provide care and mentoring are all factors relevant to the reflecting team process and family intervention.

In considering interdependence it is necessary to look again at the notion of differentiation. McGoldrick and Carter (2005:35) define differentiation as conceptualised by Bowen. It is seen as a state of self-knowledge and self-definition that is not contingent on the acceptance of others for one's beliefs, and without the need to attack others or defend oneself. These authors believe that the term 'differentiation' is misused as meaning autonomy or separateness, and that the emphasis on a distinction between thinking and feeling is perceived as elevating male attributes of logic and rationality over female attributes of emotionality. Bowen (in Grosch & Olsen, 1995:280) states that

differentiation is the ability to be in emotional contact with others while remaining autonomous in one's emotional functioning. This correlates with McGoldrick and Carter (2005:35) who suggest differentiation is more concerned with the ability to control emotional reactivity, behaviour and to think about one's responses instead of being in the service of one's impulses, fears and instincts. This still implies emotional authenticity, appropriate expression of emotions, and the ability to connect on an emotional level in personal relationships.

However, the process of unequal socialisation for men and women has resulted in assertiveness and self-directed thinking as being seen as necessary for differentiation, without consideration of the reality that is female socialisation, i.e. putting the needs of others before their own. According to McGoldrick and Carter (2005:45), this has polarised beliefs about men and women – maleness emphasises autonomy and achievement, while femaleness focuses on connectedness in relationships. This imbalance has shifted with the rise of the feminist movement, but persists and permeates one's perceptions of who one is, i.e. one's self. Gilligan (in Collier, 1987:55) challenged theories that were based on male standards and models, stating that women's perceptions of reality centre around experiences of attachment and separation, and that in ignoring differences in male and female personality development, harm is done not only to women, but is an impoverishment of our ability to understand humanity.

Collier (1987:53) states that biological, sociological, political and experiential differences in the development of men and women highlight the necessity of a "…cautious and disciplined use of the self…". According to Collier (1987:53), the practice of family therapy requires consideration of the fact that the large majority of family therapists are women, as are the family members in client families. She suggests that this requires a flexibility of therapeutic response as women speak in a "…different voice…". In the past the assumption has been that there is one model of social experience and interpretation, i.e. male. Differences between the sexes exist, and thus impact on the self, a factor which is brought to the therapeutic encounter, as well as to the experience of therapy for the client family. Collier (1987:57) goes further to suggest that when the entire human

experience is given attention and conceptualised equally, theories and concepts will be more holistic and male and female therapists will be better able to hear the clients' voices, regardless of gender.

The implications of the ideas discussed above are evident. The need for the differentiation of the family therapist is essential if he/she is to be effective in the often emotionally charged arena that is family therapy. However, the socialisation process has far-reaching consequences for men and women, with society valuing certain traits over others, and thus impacting on the development of the self. The higher number of females over males who choose a career in the helping professions suggests that the socialisation process impacts on the choice of career, as well as the way in which women may relate to the family in the therapeutic encounter. As suggested in Chapter 2 in the discussion on feminist family therapy, the family therapist who remains unaware of pervasive gender stereotyping will fail to develop dialogue within the family therapy encounter that could alter the status quo, and hence the subjugation of women.

4.2.2 Optimal Human Development

It is through our lives and life experience that the self is moulded and developed. There exists no perfect human being; personal growth is a process and the development of the self is fluid and changing. An increase in awareness and insight contributes to a more purposeful and fulfilling life, both personally and professionally. Thus while perfection in neither achievable (nor perhaps even desirable), one can enhance the self through pursuing growth, and eschewing stagnation. Human development, be it optimal or not, has implications for the personal, and hence professional self of the therapist.

Durston (2005a) explores the optimally developed human being according to the existentialist concepts of Viktor Frankl, who viewed the human being as primarily spiritual. The following points describe optimal development according to Durston's study of Frankl's work:

- Self-determining action – this involves taking a stand against coercive, inner instincts and drives, as well as the influences of society, in favour of the experience of freedom to take individual, responsible action.
- Realistic perception – this is achieved by self-distancing, in other words, the ability to have a realistic view of the self, knowing and accepting both one's strengths and shortcomings.
- Humour – this refers to humour at oneself and one's shortcomings, and not destructive, critical humour aimed at hurting others.
- Self-transcendence – Frankl believed this to be the essence of our humanness and the path to self-actualisation. We must move beyond the self in order to achieve intimate and healthy relationships with the world and with others. According to Baldwin D (1987:38), Frankl saw self-transcendence as an effect, rather than a goal or intention.
- Future directedness – this entails reaching out beyond daily life to pursue goals and achievements that are of value to the individual. The future is experienced as an opportunity to achieve potential, to leave a legacy, while the past is seen as a storehouse of experiences to be cherished.
- Work as a vocation – work is seen as an opportunity to contribute to life, a meaningful engagement of the self.
- Appreciation of goodness, truth and beauty – this involves an appreciation of the world, art and nature, and a desire to preserve this.
- Respect and appreciation for the uniqueness of others – this refers to a search for meaningful encounters with others, without discrimination, prejudice and selfish gain.
- Meaning in suffering – maturity manifests in acceptance of personal tragedy and the view of it as an opportunity for learning and growth, which deepens the meaning of life.

Optimal human development as conceptualised by Frankl encompasses traits that are relevant to the personal and professional self of the therapist and hence the practice of family therapy. Such traits could, in the opinion of the researcher, enhance the sense of authenticity of the practitioner. How one embarks on such a journey towards the development of optimal growth would be an intensely personal experience.

Merry (2002:28) explores the concept of the fully functioning person from a humanistic, person-centred perspective, and according to his thinking, self-development is a process and not an end point. The self has the potential to be congruent with all experiences available to one's awareness, implying that the authentic self does not need to distort or deny experiences. However, the imposition of conditions of worth results in denial or distortion of certain experiences, rendering the self not wholly authentic (Merry, 2002:29). Conditions of worth are acquired through learning that we are acceptable only if we think, feel and behave in ways that are positively valued by others, and experiences which are contrary to these are denied or distorted, creating a state of incongruence between self and experience, and thus the person cannot be fully authentic.

The implications of this for family therapy practice are evident, particularly in a training setting, and in reflecting team practice where a feeling of being judged and not accepted by the team may give rise to incongruency within the therapist, making it difficult to be authentic in the therapeutic encounter. Conditions of worth may inadvertently be imposed by team members upon fellow members who have different approaches to practice – feeling unable to be congruent may render the recipient inauthentic to his/her self and to the process of family therapy practice. The value of knowing one's own true self, while feeling no pressure to distort or deny one's experiences may facilitate congruency and hence being real and authentic in one's professional (and personal) life. Whether such an ideal is always, or sometimes achievable is an important consideration.

In the process of becoming a more fully integrated and authentic self, Rogers (in Merry, 2002:39-40) suggested that there would be a decreasing need to deny or distort experiences into awareness, thus the person would evidence a number of attributes:

- Be more congruent and less defended.
- Be more realistic and able to overcome personal problems.
- Be better adjusted and less vulnerable to threat.
- Be more congruent regarding the ideal self and the actual self.
- Be less tense and anxious.

- Trust one's own values and thus be more confident.
- Be more accepting of self and others.
- Be more realistic, adaptable, expressive and creative.

A comparison of the ideas of Frankl and of Rogers shows many aspects of compatibility and similarity, all of which are relevant to the self of the therapist in both personal and professional life.

According to Merry (2002:44-45), the theory of a more fully functioning person has implications for interpersonal relationships. The counselling relationship is one in which movement towards personal authenticity is likely to be enhanced. Such a relationship would be characterised by: congruence regarding experience, awareness and communication; clear, congruent communication; accurate perception and empathy for another's frame of reference; increased feelings of unconditional positive regard; and, less defence or distortion of perceptions. While such enhancement is aimed at the client, the researcher suggests that the family therapist who has the experience of such a relationship in the context of a reflecting team, who is able to feel comfortable with difference, communicate congruently and so on, would feel more creative in nurturing his/her self-awareness, more confident in his/her ability to be reflexive and thus more authentic.

Gurman (1987:114-116) attempted to measure the attributes of the therapist outside of therapy that are known to be effective for the family therapist. Five categories were identified:

- Personality characteristics including beliefs, attitudes and values about personal/intimate relationships, ethnic differences, mental health and pathology, and how such beliefs impact on intervention. Gurman does not comment on what these effective personality traits may be. For the researcher, this highlights the significance of awareness of the possible dominant discourses that may have consciously and even

unconsciously permeated our thinking and beliefs, and which we then bring to the family therapy encounter.

- Mental health – while some figures in the field of family therapy dismiss or ignore the issue of the therapist's own mental health, others argue that the mental health and psychological integrity of the therapist is essential in helping families to change. From the perspective of Bowen's theory, it would be difficult for a family to grow beyond the level of differentiation of the therapist.
- Gender – Gurman (1987:115) suggests that from the limited study of the effects of gender on therapeutic outcome, no evidence indicates that one or another gender is more effective in family therapy.
- Demographic variables such as race, social class and ethnicity influence the interactions between therapist and client family. An absence of shared experience, differing values regarding roles, rules, intimacy, conflict and so on may hamper the development of a therapeutic alliance. This suggests that Gurman believes socio-cultural differences to be a potential obstacle to effective therapeutic intervention. It implies too, a modernist position whereby objective, 'correct' values guide the intervention, and which may clash with those of the client family.

An alternative to this is the view of Combs (in Merry, 2002:54) who suggests that the belief system of the counsellor determines the degree of effectiveness. Four identifying areas that distinguish effective helpers are identified:

- A sensitive, empathic focus on the person that attends to personal meanings, rather than external data.
- Positive beliefs about people, such as trustworthiness, basic goodness, and so on.
- A positive self-concept that provides a sense of security for both client and counsellor.
- A broader focus than merely the presenting problem, one that is less concerned with an immediate solution and more concerned with the process of actualisation or growth.

These aspects, in the mind of the researcher, have a more postmodern feel, emphasising family meanings, strengths and potentials, as well as the self of the counsellor, over objective, neutral and correct intervention.

Street (1994:159-160) refers to a desire on the part of the counsellor to understand oneself and to expand one's consciousness. He refers to Bateson who offered three suggestions to acquire a wisdom that comprehends one's part in the larger interactive system. Firstly, we need to develop humility, both on an individual and on a societal level. Secondly, we need to expand our awareness and understanding of the systemic contexts of which we are part. Thirdly, we need to develop our creativity in counselling. We need to understand why we choose to be counsellors, and the context in which we undertake counselling – we need to learn the skills and be creative, and most of all, be our true selves.

In conclusion, while no human being (or family therapist) is perfect, there are aspects relating to the development of the self that may enhance the capacity for reflexivity and authenticity of the family therapist in the context of family therapy. It goes without saying that enhancing the self is reflected in the personal life of the therapist as well as the professional.

In the sections that follow extensive focus on the personal motivations, development and aspirations of the family therapy practitioner will be explored, based on the relevant literature. This literature is not necessarily written with specific reference to the family therapist, but rather concerns the choice of career in the therapeutic helping professions. The researcher proposes the relevance of this literature exploration, as few, if any practitioners are exclusively family therapists, and the self of the therapist is significant, whether intervention is with an individual, couple or family. In addition, it will be clear to the reader that the aspects to be explored, such as personal motivation, the development of the personal and professional self, and the choice of theory as embodied by the self are closely interwoven and overlapping, with much blurring of the boundaries

between the aspects, thus making clear categorisation a challenge that is in any case, unnecessary.

4.3 ON BECOMING A FAMILY THERAPIST

Goldberg (1986:5) believes that those who are called to the healing professions tend to have an intense interest in learning about themselves. An ongoing curiosity about examining one's own life and the development of personal growth provides impetus for interest in a conscious examination of the human condition. The view of Keith (1987:61) concurs with that of Goldberg, in that many therapists are drawn to the profession in an attempt to understand and deepen the connection with the self.

Historically, early practitioners of healing created systems for treating people in terms of the meaning they had made of their own suffering and life crises in their personal journey. According to Goldberg (1986:5-6), the theme of a personal journey provides the basis of the developmental process of the healing professions from the early wisdom of the shaman (or traditional healer), through to modern day therapeutic intervention. Goldberg goes on to suggest that effective practitioners utilise their own life experiences as a major source of expertise in guiding others on their journey. While the notion of 'expertise' sits uncomfortably with the values of the researcher, it can nevertheless be appreciated that the personal experiences of the counsellor may enrich empathic understanding of the experiences of clients.

Goldberg (1986:111-120) discusses the motivations of those drawn to practice therapeutic intervention, focusing on a typology conceptualised by Rychlak, which identifies three motives. These are:

- The scholarly motive includes people (e.g. Sigmund Freud) who want to learn about people in the objective sense, to draw general universal principles about human behaviour in order to help with social problems.

- The ethical motive refers to people (e.g. Carl Rogers) who focus on the development of self-determination through effective interpersonal relationships. It represents a conscious vocational choice to help others, and involves the question of human suffering, which those with an ethical motive attempt to understand.
- The creative motive refers to people who are sensitised to and identify with, the emotional pain and suffering of the human condition, and who attempt to find happiness in new and creative ways of being. While no example is provided in this motive category, the researcher speculates that counsellors with a postmodern inclination may lean toward this motivation.

Karter (2002:17) ponders the myriad reasons for choosing to become a practitioner of therapy or counselling, citing Sussman who refers to it as a "curious calling". Karter suggests that while many altruistic motives exist for the choice of a therapeutic career there are also less magnanimous reasons, such as the need to reclaim a sense of power that has been lost in living in a world that seems "…dehumanized and devoid of purpose" (Karter, 2002:18-19). Viljoen (2004:31-32) concurs, stating that while a desire to help others is a commonly expressed motivation of those entering the helping professions, this sentiment obscures a multitude of reasons for why people want to help others. Sussman (in Viljoen, 2004:32) believes there exists a "…unique constellation of underlying motives and aims…" in the choice of career in the helping professions.

In his very personal exploration of why he became a therapist, Sussman (1995:16-23) reveals a number of motivations or "illusions" that were part of his journey, and which emerged at various times during his development. These include:

- The wish for "magical powers", to be all-knowing and all-seeing and all-curing, a wish which, despite much academic training, never materialised.
- The hope of being admired and idolised to bolster self-worth, the mastery of which entails recognition of the fact that self-acceptance can never be fulfilled by receiving adulation from clients. Viljoen (2004:36) refers to an unconscious need for affection

and acceptance, rooted in early development, and which manifests in a need for appreciation or confirmation of the self within the therapeutic setting.

- The hope of repairing family-of-origin issues, which Sussman (1995:17) believes will fail to assuage the need to 'rescue' clients and thus compounds a sense of guilt if the 'rescue' fails.
- The hope to transcend feelings of aggression and destructiveness – the therapeutic encounter does not provide a refuge from negative emotions, but in fact recreates the re-enactment of painful scenarios which may resonate consciously and/or unconsciously with the therapist. Refusing to acknowledge and accept one's "shadow side" poses dangers for all participants in the therapeutic encounter. Viljoen (2004:35) refers to an unconscious need to exert power and control in a socially sanctioned way, which is confirmed in the authority conferred on the helping professions.
- The hope to escape personal problems by focusing on those of other people – according to Sussman (1995:20), the most misguided notion of all. Counselling and therapeutic work demands continuous monitoring of one's internal processes, and constantly stirs up one's own emotions, anxieties, conflicts and vulnerabilities, requiring personal therapy on a regular basis. A further aspect mentioned by Karter (2002:21) is the idealisation of a personal experience of therapy and a therapeutic process that proved meaningful, and the wish to impart a similar experience to the client. Also mentioned by Karter (2002:22) is a desire to learn to cope with loss, an aspect which is inherent in the ending of the therapeutic process. The continual exposure to the pain of people's stories can lead to a "sadness of the soul" (Chessick in Sussman, 1995:21).
- The wish to achieve a deep level of intimacy within a safe context – while the therapeutic encounter can provide a level of closeness and intimacy (within the boundaries of a professional relationship) there are limits to this type of intimacy in that it is one-directional and one-sided. Sussman (1995:21) believes that in attempting to meet the emotional demands of the therapeutic relationship, few reserves may be maintained for one's private life. Viljoen (2004:35) too mentions the meeting of intimacy needs within the context of the therapeutic relationship,

where no emotional commitment is required, yet short periods of intense intimacy may satisfy a frustrated need. It is further suggested that the helping relationship is essentially an unnatural one wherein complementarity and mutual growth are limited (Viljoen, 2004:38). The idea of mutual growth within the therapeutic relationship will be explored further on in this section.

- The hope of meeting dependency needs through vicarious attention to those of the client – the therapeutic relationship can fulfil the dependency needs of both therapist and client, however problems occur when the containment is either rejected or is overwhelming in its demands. Cancellations, no-shows and premature endings may trigger painful feelings of loss, rejection and abandonment.
- The belief that one may become free of the limitations of socialisation, adaptation and conformity, and enable clients to free themselves of those restrictions – the inevitability of certain limitations (e.g. knowledge, skill, emotional reserves, influence on clients, policy) will consistently challenge the therapist, requiring a level of acceptance.

Sussman (1995:23) concludes that the loss of such illusions may be viewed as cynical and jaded. He believes however, that a process of disillusionment is inevitable and represents a crucial, yet painful transition in the personal evolution of the therapist, preparing the way for a more accurate perception and a fuller acceptance of reality. No therapist enters the profession free of illusion, and thus Sussman (1994:24) believes that a "…mature sense of disillusionment … necessary for our full professional development, can only come within the context of accumulated clinical experience".

Out of this disillusionment come the strengths which are the reality of therapeutic practice, connecting with people who have lost trust, providing understanding and compassion for those who are emotionally wounded, nurturing growth in those who are stagnating and, according to Sussman (1995:24), gaining an appreciation of how practice facilitates personal growth both through allowing us to use the best of our selves while providing opportunities to face and accept our shadow sides. From the perspective of the researcher, the potential for growth afforded by reflecting team practice that is both

nurturing and challenging for the team members offers immense opportunity for the development of strengths and acceptance of one's shortcomings. In addition, the sense of disillusionment explored by Sussman has some resonance for the researcher, in that the initial entry by novice counsellors into the family therapeutic field seems to bring certain idealistic notions of how families should be, should function and so on (dominant discourses perhaps?), while experience may bring the sense of realism and acceptance that Sussman alludes to.

Certain motivations are also explored by Dale (in Karter, 2002:19-20), who discusses aspects similar to those expressed by Sussman. In addition to what he believes are the obvious motives of the challenge of the unknown and intellectual curiosity, a love of the truth, interest in people and compassion, less overt motives included in his discussion are: the need to make reparation for our personal experiences of pain, loss and despair; feelings of guilt relating to anger and destructive emotions; displacement as a defence against having to acknowledge one's own hidden issues; the need to have control, to manipulate and have a sense of power; vicarious healing which occurs through unconscious identification with the pain of the client, i.e. the concept of the 'wounded healer'; and, vicarious living whereby life is experienced through the experiences of the clients.

The concept of the 'wounded healer' arises often in the literature, and was initially introduced by Jung as an extension of countertransference issues (Viljoen, 2004:28; Miller & Baldwin, 1987:139). It refers to the personal hurts and wounds of the therapist that motivate not only the choice of vocation, but also the power to heal. Typically viewed in a negative light and seen as a quality of the impaired counsellor, it presents a dichotomous view of mental health, suggesting that in order to heal, the healer must him/herself be free of pathology. However, Guggenheim-Craig (in Miller & Baldwin, 1987:141) offers a more positive view, maintaining that every person has an individual healer within, which becomes activated when ill. When the intra-psychic healer is unable to heal, the person may seek an external healer (i.e. a therapist). The external healer's own vulnerability is activated by contact with the ill person, and projected onto him or

her – healing however, will only take place as the client starts to access his or her own inner healer, through being aware of the wounds and accepting them. Hubble, Duncan and Miller (1999:14) suggest a parallel idea, that the client's own "…generative, self-healing capacities…" allow them to take whatever the intervention has to offer and use it in a self-healing way. This self-healing capacity transcends the differences in therapeutic approaches and techniques.

Guy (in Viljoen, 2004:29) believes that people possessing the characteristic of empathy are attracted to the mental health professions, and that the ability to draw on one's own experiences is necessary in order to be truly empathic. This does not imply that the therapist has to have experienced the same difficulties as the client, but must have a sense of some similar experience. Empathy makes considerable demands on the person of the counsellor, and Viljoen (2004:30) cites various authors who describe consequences such as empathy contagion, empathy fatigue and empathy depletion. Such consequences link to the issue of burnout, and will be discussed later in the chapter.

In an exploration into the backgrounds of therapists, Goldberg (1986:53) proposes that a therapeutic calling has its origin in being "…sensitized to the emotional substratum of human life…" with regard to how people interact and feel about themselves. The helping professional tends to observe and be reflective, wondering about other people's motives as well as their own, and has often been cast into the role of helper or nurturer in their family-of-origin. Goldberg (1986:55) cites research that suggests that the majority of healers come from families in which a serious problem existed, either physical or psychological. Family position also plays some part in the role of family nurturer, with many therapists identifying themselves as the dominant sibling.

A further factor appears to be experience of distress in early life (e.g. illness), periods of loneliness and sometimes loss, all of which appear to "…foster an exquisite sense of the inner life of others, which becomes the hallmark of the therapist's calling" (Goldberg, 1986:57-58). Of relevance however, is that the therapist in early life became sensitised to the suffering and struggles of others and of self, perhaps leaving a residue of

powerlessness in the face of human suffering. Thus, in choosing a career in the healing professions, the therapist in adulthood 'chooses' the educational and life experiences that allow him/her to feel more adequate in dealing with human suffering. Goldberg (1986:59-60) further suggests that for many practitioners, their clients provide a "…psychological route…" to the riddle of their own family-of-origin.

Strean (in Karter, 2002:21) states that a certain "…voyeuristic pleasure…" derives from peering at people who are "…emotionally naked…". While altruism is a noble enterprise, Strean believes a sense of superiority may at times permeate the therapeutic relationship, a sense of feeling stronger and more competent than the client. However, there are times too, when the wisdom and insight of a client can cause the therapist to feel less than adequate. Viljoen (2004:34) also mentions voyeurism as an unconscious motivation for the choice of profession, suggesting that there is a wish to view tabooed scenes without having to be involved in them. Within the context of reflecting team practice the idea of voyeuristic motivations, while repugnant to the researcher, is something to consider – the very act of viewing the family through the one-way mirror lends it a voyeuristic aspect. However, the relative equality of the reflecting process at least allows the client family the opportunity to reciprocate.

According to Viljoen (2004:39), motivation for entering the field of counselling may centre on the conscious and unconscious hope that personal needs will be satisfied in the therapeutic relationship. Needs that are not met in non-therapeutic contexts, or are not addressed in supervision or personal therapy may enter the therapeutic encounter in an attempt to be satisfied. Counsellors are human beings with their own needs and issues – however, the therapeutic relationship is not the appropriate place to look for gratification of these needs or exploration of these issues. Nevertheless, Viljoen (2004:40) states that it is inevitable that the counsellor will look for need satisfaction in the professional context. Lack of awareness and insight into our motives is clearly hazardous, both to our selves and to our clients, hence requiring a continuously reflexive attitude with regard to our work.

While it may be argued that some of this data is dated, and worrying if it holds true that most therapists are from troubled backgrounds, Goldberg (1986:60) suggests that professions such as social work offered women the opportunity to be equal to men in the healing professions, and that by virtue of their gender, women are more specifically suited to being nurturant than are men. Clearly, this is in keeping with the previously explored aspects relating to female socialisation and the development of the self. Goldberg (1986:60) further proposes that the struggle with suffering is a universal human condition and that denial of one's own suffering poses a problem for the client in his/her own personal journey of suffering. Personal struggle is necessary for the practitioner's growth as a therapist, and serves as a resource for the client (Goldberg, 1986:61). In the opinion of the researcher, awareness of personal issues and a willingness to explore and resolve these is the crux, rather than **if** the therapist has personal issues, an inevitable aspect of being human.

Thus it seems that the motives for entering the healing professions may be objective or subjective, and both have something to contribute in practice. Questioning one's motives for becoming a family therapist enables one to more deeply reflect on the choice of profession, and highlights the importance of re-examining this on an ongoing basis. The capacity for self-reflection is essential for anyone choosing to journey along this professional path.

4.3.1 The Personal and Professional Self

Zeddies (1999:231) states that the relationship between a therapist's personal and professional identity is continuous, reflecting a dynamic relationship between what is meaningful or significant on a personal level and the theoretical/technical aspects that are learned and practiced. Practice in whichever arena, be it family therapy or other types of therapeutic intervention, is not just something one does – it is part of our lived experience. Developing a therapeutic style that is both personal and professional is a central developmental task. According to Rogers (in Baldwin M, 1987b:50), to be a fully authentic therapist, one has to feel fully secure as a person, allowing oneself to surrender

to the process of which one is part, and admit that understanding is never complete. This involves acknowledgement that one is imperfect, with vulnerabilities and blindspots.

According to Haber (1994:269), before we come face to face with a client family, we are confronted with influences that shape our professional role. These include culture, education, legal and health systems, professional organisations, referral sources and work settings, as well as our social system and family-of-origin experiences. Haber (1994:270) believes that the 'role' (of counsellor) is given more credence than that of the 'self', which is more mysterious, unconventional and less conscious. The self is described as using the language of dreams, metaphors, symbols, feelings and intuition. Optimally the role and the self of the therapist exist in an "…acknowledged, functional, creative and respectful marriage" wherein the self of the therapist is a co-therapist or consultant to the role of the therapist (Haber, 1994:270). For the researcher, a conscious self used as a consultant would be an asset in the complex arena of family therapy, and from experience it would seem that participation in a reflecting team is useful in fostering awareness of the self, perhaps bringing the shadow side to fuller integration.

In an earlier article, Haber (1990:376) quotes Andolfi and Angelo who state that the therapist is able to use personal affective responses in the form of images, moods and symbols to initiate and develop the therapeutic process, and that these are a constant source of information that allows the therapist to be more congruent, flexible and creative. However, this involves a risk, whereby the therapist becomes undifferentiated in the family system, loses perspective and is unable to facilitate the construction of new perspectives and solutions. The influences of culture, gender, family-of-origin issues and other idiosyncratic aspects may "…handicap…" the therapeutic process, resulting in an impasse (Haber, 1990.377).

The process of becoming a therapist is both exciting and challenging, and the path taken is diverse. Addressing the personal nature of therapeutic work, Zeddies (1999:231) believes that the emotional process the therapist undergoes while treating clients has been underemphasised in training. An aspect of working with clients (families) that is

consistently challenging is understanding the influence of one's own values, beliefs, theories and principles upon the client. To illustrate this point, Zeddies (1999:229) quotes Mitchell, who believes that the transformative power of therapy is experienced by both parties, i.e. therapist and client. Thus according to this view, the therapist not only facilitates new meanings and transformations of the client's relational patterns, but also new understandings and transformations of the relational patterns of the therapist in the countertransference. The therapist is both the "…agent and subject of change" (Zeddies, 1999:229).

To be able to provide this type of experience for clients, the ability of the therapist to form interpersonal attachments, experience life emotionally, and be able to tolerate the vulnerability and exposure inherent in the therapeutic process are key elements. The path of the therapeutic journey is often ambiguous, unexpected, even unknown, and the therapist needs to comfortable with 'not knowing' and with being open to learning (Zeddies, 1999:230). The notion of therapist attachment style and the impact on the therapeutic relationship is also discussed by Bachelor and Horvath (1999:158). The therapist with secure attachment was found to respond more effectively to the dependency needs of clients, to be more proficient in developing a therapeutic alliance, and to respond in more depth during intervention.

These comments have immense resonance for the researcher, when related to the intricacy that is the family therapy process. The family therapist needs to be able to form attachments with a number of people simultaneously, be able to empathise with their feelings as well as access personal emotions in order to monitor internal processes, and withstand the sense of exposure inherent in the process. However, in the experience of the researcher, the presence of the reflecting team members may reduce the sense of having to 'do it all', as meanings not picked up, or therapeutic paths missed, will almost certainly be addressed by team members in the reflecting process. In addition, the support and at times challenge, of colleagues provides a sense of security as well as the impetus for growth in one's professional (and hence personal) role.

White (1990:88) suggests that counsellors come to family therapy with a story that he refers to as a "…counselling career…" which has a significant effect on the course of training and hence, practice. Initial inquiries into the histories of counsellors' careers tends to generate information about formal training, degrees, experience and employment history, as well as feelings concerning the need to improve their family therapy skills. White felt a sense of dissatisfaction with the formal and general nature of these stories, and began to ask questions that he hoped would bring forth a unique account of their counselling careers. The nature of these questions concerned personal crises experienced in their careers, how these were handled, how resolution was achieved, and what new outcomes and conclusions became available that may have contributed to shaping the counselling career.

According to White (1990:88-89), the responses to such questions generated new meaning to the path chosen to pursue family counselling, but the retelling of the career story also had positive effects on counsellors' work and lives in general. From a narrative perspective, it is to be expected that the re-authoring of counsellors' stories would have such effects. White (1990:89) quotes Bruner who states that the development of an "…autobiography…" is an essential, yet seldom undertaken, personal research project. The training and development of the self in family counselling is an invitation to bring a different frame of reference and new lenses with which to see the world and therapeutic possibilities. According to White (1990:92), this can only be "…authenticated…through the expression of their own lived experience." Sharing the view of White, Street (1994:159) believes we come to the profession with a story that led us to helping others and that we need to address the issues and processes of our stories that may prevent our being authentic in our interactions with clients.

In conclusion, the development of the personal and professional self is an interrelated process demanding awareness of the many aspects that combine to form the self, from our own personal history to the theories that resonate with that self, and an understanding of how the self impacts on the therapeutic encounter with a client family.

4.4 THE RELATIONSHIP BETWEEN CHOICE OF THEORY AND THE SELF

According to Karter (2002:66), theory is a crucial element in our understanding and implementation of therapeutic practice - however it is an aspect, and not the primary force. Theory is necessary to illuminate our understanding of our clients, and can be seen as a foundation for the development of our therapeutic style. Being preoccupied with theory may "…obscure …the latent communication…" behind each client's "…analytic discourse" (McDougall in Karter, 2002:67). Without the enrichment of self-knowledge, theory may be on obstacle rather than an aid to our listening to our clients. The development of the self and a theory that is personally meaningful is highly individual, personal and creative (Comb in Merry, 2002:55).

The views of Keith (1987:61) suggest that professional training may obscure or "…put to sleep…" the self. The self is "…suffocated by education, blinded by theory and burdened by its own intelligence". A preoccupation with models and approaches may inhibit any spontaneous behaviour and thought of the therapist – in addition, the self of the therapist is seen to be a danger to the client, who must be protected from such an encounter. Keith (1987:62) states however, that if the therapist cannot be her self, neither can the client. Rogers (in Baldwin M, 1987:8) commented that healing takes place within the context of being close to one's inner, intuitive self, rendering one's presence as releasing and healing.

Goldenberg and Goldenberg (1996:365) explore the journey of professional growth which includes learning theoretical constructs and intervention skills, mastering specific interventions, and the discovery of a therapeutic style. In the process of learning from more experienced colleagues, there is a danger of becoming over-dependent on the direction of others, and of losing the unique sense of self that each therapist brings to the therapeutic relationship. Asay and Lambert (1999:39) state that a conviction of the abilities of a particular model and related interventions will prove disappointing in terms of efficacy, since comparative studies suggest little superiority of one model over another. Gilbert, Hughes and Dryden (1989:8) suggest that the more insecure the

therapist, the more likely he/she is to hide behind the use of technique, without listening and exploring with the family. Technique can hinder the development and process of the therapeutic relationship, removing the person of the therapist. The personal characteristics of the therapist determine how a particular intervention is presented to the family. Lebow (in Hanna & Brown, 1999:79) suggests that therapists need to find a way of operating that is both comfortable to them and incorporates the skills and techniques of their espoused theory or theories.

According to Satir (1987:19), techniques and approaches are tools that have different results when used by different therapists, and she suggests that the impact of the self of the therapist upon the client occurs regardless of, and in addition to the approach used. The significance of this comment by Satir resonates with the researcher in her observations of family therapy sessions – the impact of the self in interaction with the family and the therapeutic alliance are often so in evidence during a session, while technique and approach take a back seat. This observation concurs with that of Zeddies (1999:230) who believes that reliance on therapeutic techniques and skills is insufficient without taking into account the person of the therapist and his/her relational and emotional responsiveness to the client. Valkin (1994:63) explores the issue of the danger of hiding behind theory, stating that the dynamics of therapy are in the person of the therapist, rather than in the techniques and methods used. While theory and techniques are essential they should not be used defensively to avoid or minimise connection to clients.

Yalom (in Baldwin M, 1987:8) points out that it may seem that a client is responding to a particular technique, when the crucial variable is the humanity within the therapeutic relationship. Satir (in Baldwin M, 1987:9) makes a distinction between "…stylistic variables and core similarities or differences…", when it comes to the use of the self in the therapeutic encounter. She suggests that the latter refers to a shared agreement or similarity (or not), for example regarding the sacredness of the individual and their potential for growth, which therapists may have in common, while the former refers to personality, ways of working and technique, which may be very different.

Orange (in Zeddies, 1999:230) believes therapists need to "…hold theory lightly…" and be prepared to revise ideas, opinions and viewpoints in response to new information. It is necessary to be aware of the personal biases and theoretical positions that inform one's perception of the client, and to shift attention away from what one thinks one knows, towards the unfolding relational process. Baldwin M (1987:8) states that any therapy involves interaction between at least two people, and while the focus is on the client, the self of the therapist impacts on the process – denial of this impact eliminates awareness of the self as a key element of therapy.

In a discussion that conceptualises emotional availability and personal allegiances, Zeddies (1999:229) suggests that the former is at the centre of therapeutic responsiveness, while the latter may limit emotional availability to the clients. Emotional availability within the therapeutic process can represent a difficult developmental task. According to Zeddies (1999:231), focusing on 'doing' therapy may compromise emotional availability with clients, which inhibits understanding and is a pitfall for both new and experienced therapists. The former are struggling to form their professional identity, while the latter may not have continued to be reflective about subjective experience and personal dynamics. A defensive clinging to a particular theory may shield a therapist from exploration of difficult or painful personal issues. If we cannot explore our own emotions, we limit the extent of "…the human affective landscape…" to where therapist and client can travel (Spezzano in Zeddies, 1999:231). The therapist must not lose touch with her subjective experience.

Being emotionally available to clients relates to one's emotional maturity generally. Zeddies (1999:231) believes that training experiences in part determine how therapists use their own psychological and emotional resources in their work as therapists. However, emotional availability is related to, and perhaps limited by, personal allegiances, that is, attachment to or identification with a particular theory, therapist or supervisor. If beliefs about aspects of human nature are rigid and stagnant, it will prove difficult to examine new ideas, theories and techniques to which one is exposed (Zeddies, 1999:232). Overinvestment in a theoretical approach encourages the development of

blindspots in therapeutic perception. While allegiances are necessary, therapists should strive to be "…decentered…" from knowledges which may inhibit understanding of clients' meanings and experiences. This involves an increasingly reflective position about how theoretical commitments and personal/professional allegiances influence the therapeutic encounter (Zeddies, 1999:233). Zeddies (1999:233) states that knowledge held rigidly may create an impersonal and authoritarian atmosphere that restricts the "…range of therapeutic understanding and effectiveness".

The implications of the issues explored above highlight the importance of developing increased awareness of, and sensitivity towards, the significance of our personal history, beliefs and values, and the impact of the self in interaction with learned theories and techniques.

Spinelli and Marshall (2001:1) believe that of all the aspects considered regarding therapists, the one given little attention is the relationship with their chosen theoretical approach. These authors pose the question of how a lived attitude towards the preferred approach shapes not only what therapists do and how they present themselves during interaction with clients, but also how it reflects and impacts upon their general lived experience and the attitudes and ideas which embody it. One's choice of theoretical approach gives meaning and purpose to one's work. Most therapists can directly answer a question concerning the theoretical framework they use, as well as easily outline the main features of that framework. Spinelli and Marshall (2001:2) believe that an autobiographical account relating to this question would likely be presented without too much difficulty. Various accounts of personal journeys of exploration leading to a choice of particular approach have been undertaken. What is seldom considered however, is how these theories and approaches have been interpreted and re-interpreted from an "…embodied standpoint" (Spinelli & Marshall, 2001:2).

According to Gilbert *et al.* (1989:10), the theoretical orientation of a therapist reflects "…complex personal construct systems…" and ways of viewing life in general, in other words, one's personal philosophy. A positivist view of change sees the source as external

and subject to control and manipulation, while a constructivist lens views humans as the source of change related to growth, development and insight. An essential difference is evident regarding the therapist who focuses on the subjective, personal construction of meaning, memory and experience, and the therapist who focuses on objective events and behaviour.

Gilbert *et al.* (1989:10-11) refer to the distinction between "facilitators" and "regulators", typologies put forward by Raphael-Leff, and apply it to the therapeutic style. These authors suggest that facilitators focus on the subjective life of the client, see therapy as exploratory and involving growth and the development of insight – the focus is on 'being with' rather than 'doing to'. In contrast, regulators are more concerned with performance-based therapy, learning skills and behavioural change. While neither style is more valid than the other, Gilbert *et al.* (1989:11) state that the important factor is the ability of the therapist to recognise when there is a need for one direction or another in the session. Extreme adherence to either position may be problematic, with facilitators being prone to over-identification and difficulty in setting limits, while regulators may not make sufficient contact with clients and fail to provide a safe, trusting environment in which to explore feelings.

In addition to the abovementioned therapeutic styles, Gilbert *et al.* (1989:11) make the distinction between styles of containment and confronting. Containment involves a focus on empathy and acceptance of the clients' feelings, comments, and actions. This is the basis of unconditional positive regard, viewed as a core factor in the humanistically orientated therapeutic relationship. Confronting occurs when the therapist puts pressure on the client to talk about sensitive issues they may prefer to avoid, or to approach various feared situations or stimuli. Again, rigid adherence to either position may be inappropriate to the needs of different clients.

Goldner (in Haber, 1994:273) advises therapists to take "…an ethically reflexive position…" which involves observing our own thinking and practice preferences in order to avoid mistaking **our** truths for **the** truth. The practice of family therapy (or any

intervention) requires one to be mindful of how theories, values, techniques and personhood affect the therapeutic process.

A theory may have an immediate "fit', feeling as if it was made for the therapist, or it may initially feel odd and unusual. Certain aspects of the theory may be appreciated and valued, while others may cause concern, irritate or even be ignored. Understanding of how we embody certain theories is necessary since all therapists are representatives of their chosen model – the way in which a theory is put into practice may challenge and inform the therapist's professional and personal context (Spinelli & Marshall, 2001:6).

An invitation to provide an account of the personal journey of various therapists resulted in a collection of narratives which Spinelli and Marshall (2001:156) overviewed. The motivation was a curiosity toward whatever would emerge, without assumptions, preconceptions or comparisons. The narratives proved highly individualistic and idiosyncratic, provoking interest regarding aspects such as the impact of the chosen theory upon the therapist, and whether the process confirmed previously held views or opened the way for a new way of looking at things, people, oneself. According to their analysis of the personal accounts, Spinelli and Marshall (2001:166) suggest that the initial encounter with a 'chosen' or 'found' theory is a significant part of their relationship with it. A number of authors described a feeling of "…coming home", indicating a level of comfort, affirmation and resonance (Spinelli & Marshall, 2001:166-167). However, who we are at the time of the encounter with a theory will play a part in how we respond to it at that time. Some practitioners seem to be closely involved in the establishment of their chosen approach, while others are engaged in its evolution and continuing development. In the researcher's view the self of the therapist, as it develops, may find a particular theory that resonates at a particular time, while a previous encounter with the same theory may have proved unmemorable.

Spinelli and Marshall (2001:168) pose the question of what elements of the therapeutic encounter between therapist and client contribute to the experience of benefit. The significant element that appears to emerge is the extent to which the approach and the

way in which it is expressed resonate with the individual therapist. It would seem that a fit between the chosen approach and the therapist facilitates the encounter being experienced as rewarding. In addition, a perfect fit is not essential – some degree of dissonance or even disagreement can be growth-enhancing and creative, although the 'felt' recognition tends to be vivid and even startling in its impact (Spinelli & Marshall, 2001:169). Thus an approach that feels 'right' for the therapist is more likely to be practiced in a way that is authentic to the person of the therapist, and to be of benefit to the therapeutic relationship.

In conclusion, theory and technique, while necessary to the practice of family therapy are not sufficient without consideration of the impact of the self of the practitioner in the context of the therapeutic encounter. It seems that it is the relationship, rather than a particular theory that is experienced as having value for the client family. However, the fit between theory and the self is a significant aspect in practice that is experienced as authentic and meaningful for both client and therapist.

4.4.1 A Paradigm Shift

Historically the practice of psychotherapy has shifted, from the authoritarian doctor-patient relationship of the Freudian model of therapy, to one that includes the 'patient' as a partner. Freud advocated therapist neutrality for the protection of the patient, in the belief that the unaware self of the therapist could be potentially damaging (Baldwin M, 1987:10). According to Carlson and Erickson (1999:59), a great deal of literature exists that explores the significance of an awareness of personal values in the therapeutic encounter, with the general consensus being that absolute value neutrality is neither possible nor even beneficial. Value positions are taken continually in practice and according to these authors the very nature of counselling involves the sharing, discussion and consideration of values. The researcher inclines towards the view that neutrality is not possible and awareness of self in the therapeutic encounter is thus an imperative. Being aware that one is never neutral, since one's own history (personal and professional) impacts upon the self and hence on the client family, may require of the therapist an

exploration of their counselling autobiography and a more conscious choice with regard to theoretical orientation.

According to Sexton (1997:11), a radical departure from traditional modernist assumptions has taken place, requiring alterations to paradigms that have guided our thinking. The paradigm shift from the observed to the observing system within the context of family therapy has changed the way family therapy is practiced. In postmodern-oriented practice, the therapist facilitates change through active engagement in the perceptions and experiences within the family system, rather than acting on the system.

This paradigm shift is equated with Bateson's concept of second-order change, wherein change occurs in the structure of the organisation of knowledge through accommodation. Sexton (1997:11-12) suggests that such a paradigm shift requires "…a dramatic refocusing…" of the theories we use to explain culture, gender, human development and behaviour, with implications for practice, training and research. This may involve resistance and struggle, since the reformulation of our beliefs challenges our sense of security. In a study on reflecting team practice, Hanford (2004:105) states that paradigmatic shift may be a long and difficult process, a process in which she herself experienced confusion, 'stuckness' and loss of confidence in practice. This appears to be especially so for practitioners trained in more traditional approaches wherein a hierarchical therapeutic relationship is the norm and the role of expert is deemed necessary. Whilst the researcher is in no way suggesting that a family therapy practitioner must undergo a paradigmatic shift, the epistemology in the field of practice has changed significantly, emphasising the need for paradigmatic exploration, if only to consolidate one's original position, or to contemplate a possible shift.

Amundson *et al.* (1993:111-112) refer to the twin temptations of power and certainty, and state that when therapists do not adequately facilitate exploration of the clients' position, we "…fall prey to the temptation of certainty". When we impose 'treatment' from such certainty we "…fall victim to the temptation of power". These authors eloquently refer

to "…colonization…in therapy" where a commitment to expert knowledge blinds us to the experience of the family and fosters a "…colonial discourse". Similarly, in the view of the researcher, without reflection of one's paradigmatic position, there is a risk of the therapist being 'colonised' by un-contemplated theoretical models. Epistemological change requires exploration of and reflection on, our assumptions and knowledge - as family therapists it is essential to know our selves, what motivates us, what our beliefs are about the people in whose lives we intervene, and why a certain approach feels 'right', or if we still have to discover one that does. Perhaps the apparent embracing of new approaches implies that therapists have not yet found one that fits for them, or perhaps the fit changes over time, as we grow into who we are still in the process of becoming.

According to Amundson *et al.* (1993:113), clients respond to such 'colonisation' in various ways. Those who are disposed to insights or are sufficiently malleable are viewed as the ideal therapeutic population – these clients embrace the worldview of the therapist, persist with therapy, and make progress or get better. Other clients have problems which persist - they fail to 'understand' what the therapist says, and have a tenacious hold on their own view of the issue, on personal knowledge. These clients are viewed as 'resistant' and if therapists persist in their efforts to hold onto the power of their expert knowledge they may limit options to solutions. Creating a therapeutic encounter that facilitates the co-negotiation of solutions requires dialogue, curiosity and empowerment, rather than certainty and power (Amundson, *et al.*, 1993:117). This perspective links with the myth that therapy is the panacea for our psychosocial ills (Spinelli & Marshall, 2001:4). These authors believe this view to be a misunderstanding and diminishment of the value of therapy. Rather than seeing the therapeutic encounter as aimed at attaining certainty and security, it is more a recognition of the uncertainty that is part of living, and an opportunity to explore options that may enhance quality of life.

Amundson *et al.* (1993:118-119) set out a comparison of therapy guided by certainty versus curiosity, and of power versus empowerment, which to the researcher, appear to embody the paradigm shift explored in this thesis. Their points include the following:

Certainty:

- Is uncomfortable with ambiguity, needs structure.
- Diagnoses are made, with adherence to treatment based on diagnosis.
- Relies on problem-saturated descriptions of the story.
- Questions focus on linear causality.
- Observations are based on own constructions and meanings.
- Operates from a first-order perspective and does not consider the therapist/client system.
- Is concerned with teaching, explaining and expert knowledge.
- Discounts or overlooks clients' resources and strengths.

Curiosity:

- Can tolerate uncertainty and ambiguity without moving to premature closure.
- Considers the clients' meanings and experience in defining the problem.
- Takes care to discover exceptions to the dominant problem-saturated story.
- Questions are circular and explore effects of the problem.
- Observations focus on many system levels.
- Operates from a second-order perspective and considers the therapist/client system.
- Seeks the local, indigenous knowledge of the client.
- Looks for strengths and potential resources.

Power:

- Tends to be hierarchical.
- May act as an agent of social control rather than choice.
- Seeks to get the client to respond to therapy.
- May tend to rescue the client, do things for them.
- May foster dependence.
- Uses jargon to convince client of expert knowledge.
- May create a passive context.
- When frustrated, tends to restrict therapeutic variety, do more of the same.

- May unilaterally set goals for the family and be influenced by agency policy or court mandate.

Empowerment:

- Tends to be collaborative (heterarchical).
- Considers the consequences of social control.
- Seeks for the therapy to respond to the client.
- Resists temptation to rescue clients and seeks for client competencies and resources.
- Seeks to foster independence, competence and confidence.
- Avoids jargon, uses the clients' language and metaphors.
- Tends to create a context of discovery.
- When frustrated, attempts to move to therapeutic improvisation.
- Co-constructs goals and solutions with clients.

Maturana and Varela (in Amundson, *et al.*, 1993:120) prescribe an attitude of "…permanent vigilance…" if one is to keep issues of power and certainty in check. In the practice of family therapy at the organisation wherein this study occurred, curiosity and empowerment are the spoken and unspoken goals of family therapy. However, without the necessary self-awareness and embodiment of a theoretical approach that is meaningful and genuine to the self of the therapist, issues of power and certainty may arise.

According to Satir (1987:20), power has "…two faces…". One is controlling, the other is empowering, and the use of power is a function of the self of the therapist, related to self-worth. Satir believes that the use of power is independent of approach or technique, although some approaches are based on therapist superiority. A lack of therapist awareness regarding choice of an approach and a fit that coheres with the values and beliefs of the self, and unawareness of own ego needs may result in denying, distorting or projecting needs. For the researcher, it is not a question of an approach being right or wrong, but right or wrong for the authentic self of the therapist, and thus for the meaningfulness of the therapeutic encounter.

Constructivism embraces the possibility of multiple perspectives, and according to Hayes and Oppenheim (1997:32), this means that both counsellor and client should engage in a process of continual self-reflection. These authors quote Schon who suggests that in view of the complexity of human problems encountered in practice, professional education should focus on enhancing the counsellors' ability for "…reflection-in-action". The expansion of the self as a meaning-making system is the aim of postmodern education and of developmental counselling practice. According to Hayes and Oppenheim (1997:35), critical self-reflection, together with ongoing dialogue is the key element in democratic efforts to find "…unity in diversity…" and an extension of constructivism into practice.

Therefore, awareness of one's chosen approach, the fit with the self and an ongoing process of self-reflection is necessary if the family therapy practitioner is to become true to him/herself, thus enhancing authenticity in family therapy practice.

4.4.2 Experiential Aspects of Becoming a Family Therapist

Regarding the complexity of the journey towards becoming a family therapist, Haber (1990:378-379) looks beyond the usual aspects of training such as theory, techniques, live supervision and so on, to the experiential method. Experiential methods provide the opportunity to focus on the issues of the therapist and enhance awareness of how the self interacts with challenging family therapy situations. Carlson and Erickson (1999:57-58) also explore issues concerning the person of the therapist in family therapy, stating that in the past, this type of personal exploration was deficit-based, focusing on identifying biases and prejudices, and searching for problems in the family-of-origin. Understanding of personal values and beliefs about the work and so on were largely excluded.

Controversy exists concerning the fine line between experiential training and therapy. Haley (in Haber, 1990:379) supported a bill of rights that prohibited inquiry into the personal life of a trainee unless the information was relevant to the immediate therapy situation and could specifically change the therapist's behaviour in the desired way. On

the other hand, Kantor and Kupferman (in Haber, 1990:379) emphasise the necessity of experiential methods in training, believing more "…casualties…" occur when this exercise is omitted. Unidentified therapist issues can trigger serious problems in client families that may contribute to exacerbation of the family's difficulties. From an ethical perspective, exploration of personal issues that is based upon identified patterns in therapeutic work does not intrude upon Haley's viewpoint, and has as its goal, the personal and professional growth of the therapist.

The purpose of such exploration is to increase trainee/therapist awareness of situations wherein he/she may be contributing to the therapeutic impasse. Haber (1990:379-380) suggests a process that addresses personal/professional limitations that may result in a constricted therapeutic role. The process is designed to facilitate the development of the therapist in training by expanding the use of self in family therapy. The aim of this process is extensive identification of repetitive patterns occurring in therapeutic work, rather than specific cases, and encouragement to define personal responses that may be contributing to the therapeutic impasse. The researcher proposes that this process could be undertaken in the context of supervision, or on a more personal and private level through journaling. Exploration may cover some of the following issues (Haber, 1990:380):

- One's role in the therapeutic impasse.
- The manner in which one is defensive.
- The fears beneath the defence system.
- Attempted solutions for resolving the impasse.
- Gains or positive aspects in maintaining the repetitive pattern.
- Investment in maintaining the repetitive pattern.
- Parts of the story that seem to be missing, such as position in the family system or in the family-of-origin.

Haber (1990:381-382) further suggests that the internal dilemma could be externalised through the use of role-players (team members) who construct a simulated family

sculpture with a story that emphasises the relevant patterns and deals creatively with the issue in focus. The integration of various aspects of the self (e.g. flexible/rigid, warm/cool) allows the therapist a wider repertoire of behavioural alternatives to deal with diverse families and situations.

Awareness of a therapeutic impasse may alert the family therapist to consider the influence of the self within the therapeutic system. Sharing family-of-origin history offers family therapists the opportunity to evolve personally and professionally, and may assist in the dissolving of blindspots that impede the therapeutic process. In the reflecting team facilitated by the researcher, it often happens quite spontaneously that team members will share something from their family-of-origin or family-of-procreation that has resonated from the session with the client family. It seems, from the perspective of the researcher that such sharing enhances self-exploration and in consequence, self-awareness.

Dexter (in Karter, 2002:31-32) explores the negative aspects of experiential counselling training which focuses on the achievement of enhanced self-awareness as a basis for helping others towards personal growth. Dexter states that there are some risks inherent in enhanced self-awareness. With a greater understanding and knowledge of one's values may come a self-condemnation relating to past behaviour, while awareness of what is meaningful in one's life may create disillusionment with present relationships and life. The very ordinariness of daily existence may feel unsatisfying, leading to a disengagement from social and personal life.

New discoveries into psychological terrains may be disturbing and disorientating, and the process of becoming a family therapist brings risk of confusion and self-doubt, as well as possible negative effects on personal life and relationships. From a systemic perspective any change in one member of the system affects the dynamics of the system as a whole. However, according to Karter (2002:33), any turmoil and distress is a necessary consequence of experiential training, leading ultimately to a path of enhanced benefits in professional practice.

The self-reflective process promotes an ethos of self-questioning and self-monitoring which brings change that may be both beneficial and painful to the self of the family therapist, but is necessary to the process of enhancing reflexivity and authenticity.

* The researcher would like to stress that experiential methods, while not specifically part of the training at Family Life Centre, may be part of the contract between individual supervisor and supervisee. It is **not** the intention of the researcher that the qualitative research undertaken in this thesis should be an attempt to provide such experiential training for family therapists working at the organisation.

4.5 THE THERAPEUTIC RELATIONSHIP

Hubble *et al.* (1999:14) state that "…the therapeutic relationship lies at the very heart of psychotherapy". Tallman and Bohart (1999:101-102) pose the question of how the therapeutic relationship proves helpful, and suggest a number of possibilities. Firstly, the relationship may provide a corrective emotional experience which is inherently healing, repairing damage caused by toxic relationships. Also suggested is that the therapeutic relationship may provide an environment in which more appropriate behaviours are positively reinforced, and that it provides a learning opportunity for more effective relationship skills. Finally, the therapeutic relationship may provide an empathic safety net in which the client can re-experience emotion and restructure the self. Tallman and Bohart (1999:102) state however, that these factors are insufficient to explain the therapeutic change process, believing that the therapeutic relationship be reinterpreted as a resource that facilitates, supports and focuses the client's self-healing ability.

According to Asay and Lambert (1999:34), the value of therapist relationship skills has been demonstrated unequivocally, and the basis of human relational skills seems to be warmth, empathy, understanding and affirmation and an absence of blame, judgement, criticism and attack. If, as Asay and Lambert (1999:43) claim, the best predictor and even cause of therapeutic success is the therapeutic relationship, a focus on the importance of including relationship skills in training is essential, since these are "… the

foundation on which all other skills and techniques are built". These authors suggest too, that a periodic re-assessment of the use of relationship skills may be prudent for more experienced practitioners.

Arons and Siegel (1995:126) state that most therapeutic traditions acknowledge the therapist as a central component of the therapeutic encounter, but also stress that the fears, conflicts and unresolved issues of the therapist may interfere with intervention. Different terminology is used in different approaches to refer to these issues – i.e. countertransference in psychodynamic literature; being 'inducted' into the family system in family systemic theory; observer bias in behavioural therapy; and a lack of congruence in person-centred therapy. Characteristic of the person-centred therapeutic practice of Carl Rogers are three basic conditions: the authenticity, genuineness or congruence of the therapist; unconditional positive regard; and empathic understanding (Du Toit, Grobler & Schenck, 1998:ix; Baldwin M, 1987b:45). Thus for Rogers, the effective therapist should strive to be authentically him/herself, being directly available to the client, and creating a non-threatening environment in which exploration and full experience of the client's feelings is facilitated.

Congruence is a position of authenticity with regard to one's feelings, experience and behaviour, and engenders trust in the therapeutic relationship. According to Satir (1987:21), it is the basis of emotional honesty between therapist and client, and is the key to healing. Denial or distortion of some aspect of the therapist creates an atmosphere of emotional dishonesty which makes the therapeutic process unsafe for the client. Satir (1987:21) believes that this could be interpreted by the therapist as client resistance, rather than a legitimate self-protectiveness against the therapist's incongruence. Attempts to break down the defence of the client may result in a power struggle, a win-lose situation which, according to Satir (1987:22), may replicate the client's experience within their family-of-origin. These statements resonate strongly for the researcher, emphasising the necessity for finding an approach that is true to the self of the therapist, as well as congruency within the self, so that the therapeutic encounter is experienced by the client family as congruent and secure. In addition, the researcher believes that being

able to be congruent and authentic in the session allows the family counsellor to be more relaxed and confident, and less anxious.

Lantz (1993:37) states that effective Franklian intervention requires a commitment to authentic communication, and that the role of the therapist cannot be "…divested of its essential humanness". This view is shared by Satir (in Baldwin M, 1987:10) who believes that the self of the therapist can and must be used to achieve positive therapeutic results, viewing the context of therapy as empowering and healing which can only be achieved through the "…meeting of the deepest self of the therapist with the deepest self of the client". An early study on the findings of relationship factors in family therapy was undertaken by Beck and Jones in 1973, and is explored in Sprenkle *et al.* (1999:335). These researchers state that the most potent variable contributing to a positive therapeutic outcome is the counsellor-client relationship. This factor was found to be the most powerful predictor of outcome, while an unsatisfactory relationship was highly associated with family disengagement and negative outcomes for the family. Later research explored by Sprenkle *et al.* (1999:335-337), supports the conclusion of the centrality of a positive relationship with the family when evaluating outcome. Issues such as warmth, positive regard and respect are more significant than correct hypotheses and interventions. However, Sprenkle *et al.* (1999:337) caution that relationship skills alone are insufficient for effective therapeutic outcomes. The relationship is the "…vehicle…" for facilitating the process.

From an existential perspective an essential issue is the manner in which the therapist and family work together. According to Lantz (1993:37), the therapist can both facilitate and inhibit engagement opportunities in the therapeutic encounter, and hence an opportunity to discover meaning. The impact of the therapist upon the family's opportunity to discover meaning is extremely important, and effective intervention is based on certain assumptions: a commitment to authentic communication; the therapist's essential human role; the therapist's concerns as similar to the families'. The parallels between the works of Roger, Satir and Frankl regarding authentic communication and the authentic self in

the therapeutic relationship are evident, thus emphasising the importance of these elements in the therapeutic process.

Intervention involves the view of a joint venture between therapist and family with active participation in helping the family to discover meaning. The relationship is a meaning-making process, most effective when the therapist models self-transcendence. This occurs through subjective response to the family during intervention. Authentic communication is active, innovative, supportive, encouraging, explicit, engaging, observant, clarifying and optimistic – it is also, according to Lantz (1993:38) confronting, provocative, frank and challenging. Hanna and Brown (1999:77-78) believe that the hallmark of effective family therapy is the ability of the therapist to develop positive relationships with diverse people, some of whom may be in conflict with one another. The challenge of engaging diverse people, who are in conflict during the therapy session, is enormous and relates to how the therapist responds to their own and others' conflicts. An exploration of one's own patterns of thought and emotion during interpersonal conflict, the identification of coping strategies and their usefulness in professional settings may enhance awareness of this personal process, as well as the appropriateness of how such personal patterns may or may not fit with clients. According to Hanna and Brown (1999:79), perception and attitudes are aspects that relate to the goal of becoming "…relationally versatile…".

The Franklian family therapist will not present him/herself as a blank screen or as an external, strategic manipulator of the system. Frankl (in Lantz, 1993:39) suggested that client and therapist are more alike than different, that every human being must face tragedy, suffering, existential anxiety and death. The presence of human tragedy in the lives of therapist and client family has consequences to the outcome of intervention. Acceptance by both can lead to engagement and self-transcendence, while denial cheats both the family and the therapist of an authenticity that is based on the shared experience of finding meaning in a "…chaotic and painful universe" (Lantz, 1993:39).

Meaningful communication between family and therapist depends upon the acceptance by the therapist of his/her own evolution. The realisation that one is never fully 'trained' or all-knowing allows a fundamental creativity, and according to Lantz (1993:38), the therapist's own willingness to change may be a vital asset in helping others. The potential to help is linked with the changing relationship to the self, others and the world in general. The effective family therapist cannot be a mechanical, programmed 'robot' with a set of techniques in response to family distress. In the experience of the researcher, communication with client families that is authentic, spontaneous, and creative seems to enhance a therapeutic connection that facilitates movement and growth.

Conscious emotional responses can provide important sources of information, revealing subtle processes in the therapeutic relationship. Arons and Siegel (1995:126) believe that problems arise when emotional responses are unconscious, and that to be effective as counsellors we need to recognise and understand the source of our emotional responses. Concurring with this view, Rogers (in Baldwin M, 1987b:46) stresses the importance of being aware of one's own feelings, and should these be contrary to the conditions of the therapy, require expression if they are an issue in the encounter. It is important to be aware of when it is appropriate to express one's feelings. This involves an understanding of all one's facets and characteristics, recognising when these should be included in the therapy, and when not. Congruence is being aware and willing to express the feelings of the moment, not every feeling as it arises within the counsellor.

The views of Buber on the therapeutic relationship are explored by Baldwin D (1987:34-35). Buber believes the helping relationship to be one-sided and unequal, focusing on the experience of the client. True dialogue occurs when partners turn to "…one another in truth…express themselves without reserve and are free of the desire for semblance…". This implies that neither person is governed by thought of the effect on the other, thus according to Buber, even the most authentic and genuine therapeutic relationship is not really a genuine dialogue between equals with equal perception of each other's experience and reality. The fundamental quality of therapy is authentic presence, being totally available and in tune with the other. Going beyond the concept of unconditional

positive regard of Carl Rogers, Buber advocated the offering of one's total being to the other. The therapist who does not 'know' in advance is receptive, ready to be surprised and cannot know what method will be used beforehand. Buber (in Baldwin D, 1987:35) believes it is far easier to impose one's self on the client than to leave him/her untouched and to him/herself, stating that the "…real master responds to uniqueness". For the researcher, this quote of Buber is significant - certain approaches used by a family therapy practitioner may be experienced by the client family as an imposition. However, incongruent practice on the part of the therapist, e.g. using a humanistic, or postmodern approach that is not authentic to the self may render the counselling process unsafe. Far better to be aware of one's values, beliefs and so on regarding families and change than to feign a theoretical fit that is incongruent.

Karter (2002:107) quotes from a study done by Stern, Sander and Nahum who came to the conclusion that anecdotal evidence suggests two significant aspects in the perception of successful intervention: the first is key interpretations that assisted in the creation of meaning; the second concerns the authentic personal relationship. Failure or premature termination of counselling was not because of incorrect interpretations but because of a lack of meaningful connection between the therapeutic participants. A further discussion by Clarkson (in Karter, 2002:107-108) stresses the importance of the therapeutic alliance, which has the ability to undermine the quality of the therapy more seriously than any other aspect, including the chosen approach or model. Hanna and Brown (1999:77) concur that the therapeutic relationship is a crucial factor in the effectiveness of intervention, citing research which suggests that the espoused model of intervention had little to do with clients' reported experience. Therapists attributed therapeutic success to the use of certain techniques (in this case, solution-focused) while the clients consistently reported a strong therapeutic relationship as a critical aspect of the outcome of therapy. The researcher questions whether a family therapy practitioner can facilitate a strong therapeutic alliance while in the insecure position of trying to practice an approach that does not fit with the self.

The ability to be real in the relationship is a key factor, and according to Karter (2002:112), this entails being authentic or true to oneself in the face of pressures from supervisors and theories that can act as a "…therapeutic straitjacket". In accepting that we can never be perfect, nor aspire to be, we are allowed to relax into the therapeutic encounter and be more perceptive to the needs of clients. As discussed in the previous section, too much focus on technique and theoretical application may hinder the development of the therapeutic relationship. The issue of pressure from supervisors and theories upon the self of the therapist mentioned above, strikes a chord in the mind of the researcher. In the reflecting team practise, members may feel this pressure, perhaps to emulate the style of others, 'practice' techniques, achieve goals (their own rather than the family's), and so on, in preference to developing the therapeutic relationship, which may be slower and more process-orientated.

Lebow (2005:91) states that research typically focuses on different therapeutic interventions while ignoring the person who makes use of such interventions. The skills, personality and experience of the therapist are usually viewed as side issues to be controlled for, in order to ensure comparable research results, but according to Lebow, studies that do consider the personal styles and relational skills of therapists have shown that these qualities have a greater impact on outcome than the interventions used. In addition, comparative studies of different interventions often show more variation within a group receiving one type of intervention than between groups getting different kinds of intervention. This outcome variation stems from relationship factors. Lebow (2005:91) believes that individual characteristics are probably the most important factor in the success or failure of therapeutic intervention.

A recent study by Orlinsky (in Lebow, 2005:91-92) explored what factors therapists bring to the therapeutic relationship, specifically personal and professional aspects, and experience of the therapeutic process at different stages of their careers. Orlinsky identified two distinct patterns of practice, referred to as "**healing involvement**" and "**stressful involvement**". The former refers to therapists experiencing themselves as fully engaged with high levels of empathy, good communication skills, feelings of

effectiveness and confidence in dealing with difficulties constructively. In contrast, the latter entails feelings of boredom and anxiety during sessions, and difficulties with clients which tend to be dealt with by avoiding engagement. Lebow (2005:92) believes that most therapists will recognise both patterns in practice.

Orlinsky (in Lebow, 2005:92) goes further in his exploration of these patterns, identifying four sub-patterns. These are: **effective practice** which is characterised by much healing involvement and little stressful involvement; **challenging practice** which includes much healing but also much stressful involvement; **distressing practice** which has high stressful and little healing involvement; and, **disengaged practice** characterised by little healing or stressful involvement. The findings of this study revealed that more than 50% of therapists felt they experienced effective practice, with 25% experiencing challenging practice, and the remainder experiencing practice as distressed and/or disengaged. In the opinion of the researcher the implied outcome of around 25% of therapists being distressed or disengaged in practice is cause for concern. Further studies by Orlinsky and Ronnestad (in Lebow, 2005:92-93) looked at therapists over their professional life cycle. Their findings included:

- Most therapists view growth as a lifetime task and value continuing development – feeling that they are not developing increases susceptibility to distressed or disengaged practice.
- Experience increases healing involvement and lessens stressful involvement – beginning therapists experience the highest levels of stressful involvement.
- High levels of theoretical breadth, variety in case loads and current experience of growth increase healing involvement and effectiveness.

The findings suggest that continued renewal and change, as well as professional growth and a sense of improving over time are essential for remaining effective as a therapist. In the context of family therapy practice at Family Life Centre, the researcher believes that reflecting team practice offers a potentially enriching growth experience, certainly from an experiential point of view, and hopefully in the future, enhancing the theoretical

component. In addition, it provides the opportunity for variety in practice. Increased theoretical breadth and development of the self may enhance 'healing involvement' as defined by Orlinsky (above).

According to Worden (1999:49), therapists bring to the therapeutic relationship not only their academic/theoretical training experiences but also their personal experiences and own issues involving their family-of-origin and life cycle stage. These factors shape the unique worldview of each therapist and impact on the capacity to form therapeutic alliances. Therapists carry with them the "…paradigm of their family-of-origin" and are thus susceptible to family systems at work (Worden, 1999:50). There may be many shared elements, e.g. religion, culture, values, life cycle stage, and so on which enable both client family and therapist to feel comfortable and connected. However, the danger could lie in a mirroring of family dynamics which may prolong a sense of being 'stuck' and make change more difficult.

Arguments exist for both exploration of therapist's family-of-origin issues (i.e. Bowenian theory which suggests family work as essential to developing therapist neutrality) and structural and strategic schools who do not believe this to be relevant to success as a family therapist (Worden, 1999:51). Constructivist approaches would argue against the concept of therapist neutrality, and the researcher believes that self-awareness into one's family-of-origin issues is necessary in working with families, if only to enhance sensitivity to the potential impact of our personal paradigm on the families with whom we intervene. The researcher has witnessed in practice how parallels in the dynamics of the client family and the therapist can become hooked into one another, resulting in blindspots, and echoes of pain, discomfort or loss.

The therapist's paradigm strongly influences the therapy process. Weakland (in Hoyt, 1998:9) states that just as one cannot not communicate, one cannot not influence. Therapists both influence and are influenced by their clients and, according to Weakland, our choice is to do so deliberately and responsibly, or without reflection and possibly even with an element of denial. The implication of this is evident, requiring of the

therapist the consideration of every aspect of intervention. While this does not mean that the therapist has all the knowledge, power and control, we also cannot pretend that we have no influence and are not contributing to the therapeutic process. From a constructivist perspective, therapy exposes power and privilege that subjugates people, and practice is aimed at co-creation, collaboration and self-determination in a venture that is an exercise in ethics (Hoyt, 1998:10-11). The argument against issues of power and certainty which were discussed in the previous section (4.4.1) is also relevant in the context of the therapeutic relationship in that an attempt to 'colonise' the client family with our own perspectives, viewpoints and assessments impacts on the therapeutic relationship in ways that may render the process meaningless and unhelpful, or even worse, harmful.

Baldwin D (1987:41-42) states that the use of self is an essential element in therapy and that the relinquishing of control is precisely what enables clients to rediscover and regain their own sense of control over their own lives. However this act loses its authenticity if used as a technique – rather it is a real and personal belief in one's self and in the self of the other. Paradoxically, the use of self implies a deliberate 'non-use' or suspension of self in the usual sense (Baldwin D, 1987:42). Baldwin D goes on to suggest that depending on the personal beliefs or needs of therapists, this position may prove impossible, nor is it the preserve of any one approach or theory. It also does not imply that knowledge, skill and experience are irrelevant. These views highlight the necessity of enhanced knowledge of the self, the theory espoused, and understanding the impact and relevance of the self upon the therapeutic relationship.

From the above discussion, it is apparent that the therapeutic relationship is the most significant aspect of the counselling process, regardless of the approach followed. Awareness of the therapist's own emotional responses, family history and understanding of the significance of the impact of the self upon the therapeutic encounter are important aspects relating to the therapeutic process and outcome.

4.5.1 Cautionary Aspects in the Therapeutic Relationship

According to Viljoen (2004:23), the hazards of practice are extensively described in the literature. In his own review of the literature, Viljoen (2004:23- 28) focuses on four aspects considered to be potentially problematic. These are:

- **The impact of professional relationships on personal life**

A study of attitudes towards relationships by Henry, Sims and Spray (in Viljoen, 2004:23) states that a "…unidimensional attitude…" tends to be adopted by most practicing therapists which is based on therapeutic style, and which impacts on everyday relationships. Thus for example, an empathic style may preclude reciprocal self-disclosure in non-therapeutic relationships, or a style based on everyday conduct in non-therapeutic relationships may have implications for the efficacy of counselling. Viljoen (2004:24) hypothesises that different theoretical approaches may make the therapist vulnerable to different demands, e.g. the systemic therapist may become undifferentiated in the family system and lose a sense of perspective; a psychoanalytic therapist may over-interpret events from childhood.

- **The dangers of reflection**

While reflection and monitoring on one's practice, professional development and own needs is an essential and positive quality of an effective practitioner, Viljoen (2004:25) suggests that it can contribute to a sense of social isolation. Continuous professional reflection allows the personal life to become more accurately understood and integrated into the professional life, allowing painful personal issues to be used in ways that may be helpful for the client. If however, the process of professional individuation has not taken place through continuous reflection, the therapist may be 'wounded' and act in ways that are harmful to the client (Viljoen, 2004:26). A reflexive attitude in non-therapeutic contexts may preclude spontaneous interaction and a danger of assuming an observer role in one's personal life. The issue of the wounded healer was explored in a previous section (section 4.3).

- **The loss of intimacy**

The time and energy expended on clients may cause the therapist to lose sight of their own personal health, priorities and needs, as well as of the needs of family and friends. In facilitating a therapeutic climate in which the client can explore painful themes, hurtful emotions may be projected onto the therapist (in the transference process), and even contribute to the relationship being experienced as traumatic. The conscious or unconscious satisfaction of social needs on the part of the therapist may result in him/her becoming isolated, disappointed and disillusioned (Viljoen, 2004:27).

- **Stress, burnout and secondary trauma**

Many symptoms of stress associated with the mental health professions are evident, for example, exhaustion, depression, disillusionment, irritability, empathy or compassion fatigue, insomnia, a sense of meaninglessness, as well as psychosomatic symptoms such as headaches, muscle tension and hypertension (Viljoen, 2004:28). Secondary traumatic stress, relating to working with traumatised clients is a further risk for the therapist, with symptoms similar to post-traumatic stress disorder. The issue of burnout will be discussed in more detail in section 4.7.

Haber (1990:377) describes some cues that may alert the family therapist to issues of fusion or disassociation within a family system. Obviously these are deeply personal and depend on the therapist's personality and fit with the family, as well as the issue of healing versus stressful involvement mentioned by Lebow (2005:91) and explored earlier in this chapter. These may be:

- Dreading appointments with certain clients.
- Watching the clock.
- Being incongruent in not expressing silent boredom, anger or other feelings with a family.
- Aligning with one family member.
- Blaming one individual for the problem.
- Feeling impatient.

- Lecturing or debating with the family.
- Feeling guilty about the session.

According to Haber (1990:377-378), aspects such as these or similar, may indicate that the therapist is utilising a limited range of behaviours that may become polarised (e.g. helpful/helpless, tough/soft) and limit flexibility. The ability to see one's own contribution to a therapeutic impasse allows options for correcting the situation and may prove to be a learning experience for both therapist and family. In the experience of the researcher, while such aspects may arise in the context of family therapy, the reflecting team format (ideally) provides a supportive structure in which to explore such feelings, as well as enhancing awareness of how the self may be impacting upon the therapeutic encounter with the client family.

Goldberg (1986:73-74) explores some "…unconscious satisfactions…" that may adversely impact on the therapeutic relationship. In being given the 'power' to ask clients questions regarding their feelings, actions, relationships and so on, therapists are given a privilege that may be misused if there is a lack of integrity and/or unawareness of our own unfinished business. Unconscious defence mechanisms may be acted out in the therapeutic encounter.

It is evident that there are many dangers inherent in the therapeutic relationship that have the potential to be harmful to both the recipients of family therapy, and to the therapist him/herself. However, awareness and the opportunity to explore these aspects, should they arise, in a safe, non-judgemental context may help to minimise the risks to all involved.

4.5.2 The Therapeutic Role and Evaluation

Worden (1999:53) defines his personal view of the therapeutic role: the therapist is responsible for promoting an atmosphere conducive to change, and in doing so, forms an alliance in collaboration with the family. Therapy thus becomes a joint effort between

therapist and family, with therapist as facilitator, participant and observer. While showing the way through supporting, questioning, or challenging the family, the therapist gives the utmost respect to the family's capacity or willingness to change, accepting that change is both their responsibility and choice.

Lankton, Lankton and Matthews (in Hanna & Brown, 1999:80) generalise about two qualities of the therapist that are significant in therapy. The first is that the therapist has an extensive, pragmatic understanding of people and of coping with the stresses of life. The second is the ability to step outside oneself into the world of another person, while at the same time retaining an awareness of the pragmatic understanding of people and stress (in other words, the operational aspect of empathy). In addition, the research of Figley and Nelson (in Hanna & Brown, 1999:82) explores therapist flexibility. Being respectful of difference and understanding that one reality does not work for everyone are characteristics of a family therapist who has learned to be flexible. The constructivist position is central to the view that reality is subjective and individualistic. In the absence of a specific view of reality, the therapist is free to consider different realities, rather than imposing a theoretical reality onto the client.

Hubble *et al*. (1999:7) discuss various studies related to the effectiveness of therapies, and explore the work of Frank and Frank who identified four common features in effective therapeutic outcomes. They are: a confiding relationship of emotional availability with a helper; a healing environment; a rationale or cognitive scheme that provides a meaningful explanation for the clients' problems; and, a ritual or procedure that requires the active participation of both client and therapist which is perceived as a means of restoring emotional wellbeing. Hubble *et al.* (1999:6-7) suggest that the search for what works in effective therapy is reflected in the plethora of models and approaches available, none of which have proved superior to others. Research has shown that therapy works but our understanding of why remains elusive.

A further study by Lambert (in Hubble, *et al.,1*999:8-10) proposed four therapeutic factors as the key elements relating to improvement of client issues. The first is

client/extratherapeutic factors, which refers to aspects that are part of the client's life that assist healing – they may be the client's own strengths and resources, environmental factors and chance events, such as a new job. These factors are estimated to account for 40% of outcome variance. **Relationship factors** represent 30% of successful outcome variance, and are found in the therapeutic encounter regardless of approach used. They include empathy, warmth, acceptance, affirmation, encouragement, and more. Such factors are judged to be responsible for most of the therapeutic gain in intervention. The third factor is **placebo/hope/expectations** which, according to Lambert (in Hubble, *et al.*. 1999:9) contribute to 15% to therapeutic outcome. The knowledge of being assessed and 'treated' according to a therapeutic rationale creates an expectation of "…restorative power…". The final factor is **model/technique**, seen to account for 15% of improvement. Depending on the theoretical orientation of the therapist, different content will be emphasised in counselling. Despite this difference, most therapies share the quality of expecting the client to engage in some actions relating to change.

According to Hanna and Brown (1999:267), therapists should take the opportunity to evaluate the therapeutic processes. Reflecting on the expectations for the self, the client and the process are important aspects to consider. They suggest certain questions that may help with an evaluation:

- Is the therapist expecting too much from the family?
- Is the therapist becoming dependent on the client's behaviour for a feeling of success?
- Does the therapist utilise the strengths and resources of the family in proposed solutions?
- Has the therapist found a way to value the unique and idiosyncratic style of the family?

Questions such as the above may provide a form of self-supervision that may further therapist development. Obviously formal supervision and objective evaluations of the therapeutic process are also part of such development. Again, in the view of the researcher, participation in a reflecting team may enhance awareness of evaluative

aspects, through post-session reflections upon the therapeutic process – this may include self-reflection on the emotions, experience and behaviour of the primary therapist, but also those of team members. In the experience of the researcher many, if not most practitioners engage in this type of evaluation quite spontaneously after a session, and are often insightful and at times critical of their intervention. The support of the reflecting team, which may also include challenge, may be encouraging and promote reflexivity.

In exploring the self of the therapist in the family therapy arena, the researcher believes that the 'voice' and experience of the family with regard to this type of intervention is extremely relevant. Thus, certain aspects relating to the clients' experience of family therapy will be briefly examined, as a component of evaluation.

Coulehan, Friedlander and Heatherington (1998:17) conducted research to explore aspects of family therapy sessions that were judged as successful in terms of transformation of the initial construction of the problem. The findings of their research showed the following results (Coulehan, *et al*., 1998:25-29):

- Family members were given the opportunity to express their individual views – despite distractions and disruptions, the therapist was persistent in pursuing each member's response to the problem, expressing interest and curiosity about each person's view.
- Interpersonal aspects of the problem or potential solution/s were highlighted – discussion concerned not only the problem and the 'identified patient' but also the relationships of family members to one another, to the problem (their contribution) and the solution.
- Exceptions or differences regarding the problem – successful sessions entailed discussion of differences, differing viewpoints, degree to which change has already occurred and exceptions to the problem, highlighted and elaborated upon by the therapist.

- Acknowledgement by family members of positive attributes of the 'identified patient' – therapists who are attuned to blame may explore, block, reinterpret or reframe blame when expressed by family members.
- Recognition of the contribution of family history/structure – therapists explored important and relevant aspects of the family's history, viewed as factors that may contribute to the problem.
- Identification of family strengths and values associated with change – therapists highlighted or introduced values that could be related to transformation.
- Acknowledging the hope or possibility of change – the therapeutic climate was marked by a shift in affective tone, from blame to a more hopeful, supportive stance. This entailed a response by the therapist to the emotional expressions of love or commitment, and an invitation to the family members to express their feelings.

Coulehan *et al.* (1998:32) believe that these aspects provide a better understanding of how to facilitate transformation in family therapy sessions. However, they caution that successful outcomes may be the result of mutual understanding concerning the goals and process of treatment, as well as the emotional bond between therapist and family members.

Treacher (1995:197-219) explores a number of guidelines developed during his work with families that promote what he refers to as "…user-friendly practice…". A summary of these guidelines follows:

- User-friendly family therapy is based on the core assumption that ethical issues are of primary, not secondary importance – therapy is recognised as essentially a human encounter first, and a therapeutic encounter second, and that the power difference between therapist and user is recognised as a source of danger and difficulty that must be addressed – failure to address this power differential opens the way to abusive practice. Treacher (1995:198-199) believes that ethical considerations have not been at the forefront of the thinking of leading theoreticians of family therapy, and that the notion of scientific neutrality is a smoke-screen behind which to hide. In practice,

many forms of unethical frameworks have structured family therapy in the past, and Treacher believes that in addition to a professional code of ethics, a more personal ethically based practice could be both possible and meaningful.

- User-friendly family therapy is based on the assumption that the development of a therapeutic alliance between therapist and client is crucial to the success of therapy (an aspect discussed in detail in previous sections of this chapter). Collaboration in working together seems to be the overall significant factor in whether counselling is judged to be successful or not (Hunt in Treacher, 1995:199). Hunt (in Treacher, 1995:200) quotes Strupp who believes that the creation of a good therapeutic relationship is the challenge that every therapist must meet. A stance of warmth, acceptance, respect and understanding, coupled with deliberate efforts to avoid criticism, judgement, or react emotionally to provocation creates a framework and atmosphere unmatched in any other human relationship – how to create that relationship and use it to empower clients represents a challenge for the therapist. According to Treacher (1995:201), it may even prove necessary to have a conversation with clients about relationship issues; to ask clients directly about their sense of liking and trust of the therapist places the therapeutic alliance at the centre of therapy, and although this may seem risky, failure to ask such a question may result in a therapeutic impasse sooner or later. In addition, Treacher (1995:203) believes that a therapeutic alliance with different families may take different forms, with families aspiring to various levels of goal achievement. It is also possible that some families may not share a belief in the importance of the therapeutic bond, perhaps wanting advice rather than engaging in a relationship-building process with the therapist.
- User-friendly family therapy recognises that the structure of the therapeutic alliance is unbalanced and that successful intervention partly depends on the creation of a context that facilitates change. The therapist must do his/her best to ensure that the therapeutic relationship is developed, and create a context that is not disempowering by enabling clients to make an equal contribution to the process. Every therapist has both strengths and vulnerabilities, and in spite of his/her best efforts may be unable to form strong alliances with some clients. Treacher (1995:205) believes that it is no

dishonour to respectfully transfer a family to a colleague if the therapist can acknowledge his/her inability to help a particular family.

- User-friendly family therapy recognises that therapists generally fail to understand the stress and distress experienced by families, especially at the first encounter with the agency. According to Treacher (1995:205), therapists may be insensitive to the fact that families may find it difficult to come for therapy. The impact that any agency has on a client encompasses aspects such as the initial phone call, reception, waiting room, and so on, to the actual therapeutic encounter which may include the use of videos and one-way mirrors (as is the case in Family Life Centre). Providing users with information about the process of family therapy is essential – this requires informed consent and being made aware of their rights. At Family Life Centre, clients are informed, prior to the first session, of reflecting team practice at the Centre and have a choice regarding team observation and feedback, and being videotaped. From the researchers experience however, the actual initial session often comes as quite a shock. Treacher (1995:207) believes that a longer initial session with a less hurried pace may allow users to feel more comfortable and facilitate the engagement process, an opinion with which the researcher concurs.
- A user-friendly approach recognises that family members cannot be treated as if they are identical members of a system – class, gender, sexual orientation, age, disability, ethnic origin, religion and socio-economic background are some of the more obvious sources of difference which require consideration if intervention is to be successful. According to Treacher (1995:208), therapists need to prepare themselves to avoid stereotyping in their work with clients who differ from themselves. The researcher suggests that even when clients come from similar backgrounds to the therapist, we need to remain acutely sensitive to the individuality and uniqueness of their experience. Treacher (1995:208) goes on to state that knowledge of the family construct system enables the therapist to be more aware of the way the family sees the world and avoids many of the errors inherent in the 'expert' position which may mislead the therapist into believing that he/she knows how a family functions, based on generalisations about apparently similar families. Every family has its own "…microculture" (Treacher, 1995:209).

- A user-friendly approach to family therapy assumes that integrated models of therapy offer clients ways of working that are likely to suit them. No one model of counselling suits all possible clients. According to Treacher (1995:210), integrated models seem to be the way forward because they address the basic issue that clients may require different interventions at different times in their experience of therapy. The idea of integration was explored in Chapter 2. If integration is to be considered, the researcher stresses the importance of reflexive practice in knowing which approach feels genuine and authentic to the self, and if one is purist in practice, to be aware that that approach may not be the most appropriate for a particular family.
- User-friendly family therapy emphasises the necessity of therapists developing a position of self-reflexivity – this may include attending their own therapy to address difficulties. Treacher (1995:212) believes that therapists who seek to remain aloof and distant in the therapeutic encounter run the risk of internalising the stress that is inherent in the profession. According to Treacher (1995:213), if we value the significance of the therapist's contribution to creating a therapeutic alliance, issues such as job satisfaction, level of self-esteem, enthusiasm and flexibility are aspects for contemplation by agencies which provide nurturance and support for their counsellors. These aspects link with the concept of burnout, which will be discussed later in the chapter.
- A user-friendly approach to family therapy recognises the need for research to contribute to the development of theory and practice. The use of therapies that are not supported by research data exploring the efficacy of a particular approach are open to criticism, while the experience of families and their satisfaction with services must be evaluated and form a crucial aspect of the assessment of any service (Treacher, 1995:213). Unmonitored practice cannot be defended from an ethical standpoint. This relates back to the first guideline – that therapists require an independent monitoring and audit of their work. In addition, according to Treacher (1995:215), active engagement in reflective practices incorporates reflection on the family's experience of therapy – the use of diaries, self-report checklists, and so on may contribute to reflective processes. As previously mentioned, the researcher believes that the reflecting team process has the potential to enhance reflective practice.

- User-friendly family therapy emphasises the importance of training and professional development in influencing the attitudes of therapists. Thus, family therapy training needs to be trainee-friendly, and based on ethically sound principles. Treacher (1995:216-217) believes that authoritarian positions have permeated family therapy training programs, neglecting trainee perspectives and perpetuating a theme of neglecting family perspectives. The ethics of training should reflect respect for the skills and person of the therapist, and the creation of a training environment in which a relationship of trust can be built. Apart from a position of cooperativeness between trainer and trainee, a user-friendly approach espouses the belief that therapists undertake personal work of many kinds to enhance their role as a therapist which is crucial in determining the outcome of the therapy process. Aponte (in Treacher, 1995:217) suggests that training integrate existential and human aspects of the therapeutic relationship with the more technical aspects – this requires the therapist to be trained in the use of the self, in being able to utilise aspects of their personal history and style to help create new therapeutic possibilities for clients. This position has immense resonance for the researcher, since it reinforces the personal belief in the significance of a holistic approach to theory, training, self and reflexivity for authentic practice.
- User-friendly family therapy recognises that therapy has limitations in helping clients and that some families may need support in gaining access to material resources that affect their well-being. A therapeutic approach that does not address the practical problems of families (e.g. housing, illness) cannot succeed in helping clients to become empowered and in control of their lives. At times it is necessary to utilise professional networks to attempt to create change for the family, to find allies and advocates who can help people to secure the basic necessities of life (Treacher, 1995:217-218). Therapists may create a 'gatekeeper' position to other resources (e.g. self-help groups) in their failure to inform clients of possibilities that may assist them.

In the opinion of the researcher, ongoing evaluation of family therapy intervention is essential. At Family Life Centre it is seldom undertaken in any formal manner, an issue requiring further contemplation. While not the primary focus of this study, the

exploration above concerning user-friendly practice raises awareness relating to important aspects that require consideration and could prove helpful in evaluating intervention.

Goldenberg and Goldenberg (1996:374) discuss possible learning objectives of a family therapy training program, which may have relevance in considering the concept of evaluation. Depending on the theoretical and therapeutic outlook of the training organisation, goals may include a focus on the acquisition of theory, skills and experience in the field, as well as on personal growth and development. In a seminal work from the 1970s, Cleghorn and Levin (in Goldenberg & Goldenberg, 1996:375) specified some training goals, which still have relevance today. (The researcher would like to qualify, perhaps presumptuously, by suggesting that certain of these goals are modernist in outlook, while others fit more comfortably into a postmodern perspective.) These are:

Executive skills:

- Developing a collaborative working relationship with the family.
- Establishing a therapeutic contract.
- Clarifying communication and stimulating transactions.
- Helping the family to label the effects of interactions.
- Remaining outside the family system – this aspect is, in the opinion of the researcher, contingent on the approach being adhered to.
- Focusing on the problem.

Perceptual and conceptual skills:

- Recognise and describe interactions and transactions.
- Describe a family systematically and assess the presenting problem – again, in the researcher's view, depending on the approach being used.
- Recognise the effect of the family on one's self.
- Recognise and describe the experience of being part of the family system.
- Recognise one's idiosyncratic reactions to family members.

The essential role of the therapist is to facilitate constructive problem-solving communication. Cleghorn and Levin (in Goldenberg & Goldenberg, 1996:376) suggest further advanced training goals aimed at assisting 'stuck' families with unproductive transactional patterns.

Executive skills:

- Redefine the therapeutic contract periodically.
- Demonstrate a relationship between transactions and the symptomatic problem – the researcher speculates that from a postmodern perspective, perhaps contemplation of the meaning of the problem for the family members?
- Be a facilitator for change, not a member of the group.
- Develop a style of interviewing consistent with one's personality.
- Take control of problematic transactions (e.g. reframing, confronting).
- Work out new adaptive behaviours and rewards for them, again depending on the approach followed – solution-focused therapists may empower families to do this for themselves.
- Relinquish control of the family when adaptive patterns occur – a very modernist perspective, in the opinion of the researcher.

Perceptual and conceptual skills:

Regarding the family:

- Understand symptomatic behaviour as a function of the family system.
- Assess the capacity of the family for change.
- Recognise that change in the family is more threatening than recognition of the problem.
- Define key concepts operationally.

Regarding oneself:

- Deal with feelings about being a change agent, not merely a helper.
- Become aware of how one's personal characteristics influence one's way of being a family therapist.

- Assess the effectiveness of one's interventions and explore alternatives.
- Articulate rewards to be gained by family members making certain changes.

While many of the abovementioned aspects seem to relate to a modernist style of family intervention, it is not the intention of the researcher to promote one epistemology over another, merely to raise awareness of one's personal paradigm in order to better understand one's role, and thus practice in a way that is more authentic to the self of the therapist.

The importance of understanding one's role and the aspects incumbent upon the family therapist are highlighted in the discussion above. Of significance too, are the views and opinions of family therapy recipients in order to consider aspects relating to evaluation and the experience of family therapy from those who receive it.

4.6 ENHANCING SELF-AWARENESS AND REFLEXIVITY

Various authors suggest possibilities to enhance self-awareness and gain insight into the unconscious processes that may interfere with the therapeutic relationship and hence, intervention (Karter, 2002:40; Arons & Siegel, 1995:126-127; Grosch & Olsen, 1995:284). While some of the aspects to be discussed are also applicable in the context of burnout prevention (section 4.7), they are explored here in relation to enhancing reflexivity.

Individual therapy is recommended to explore and raise consciousness of personal issues that may impact on professional intervention with clients. Family-of-origin work may help therapists to explore any unresolved issues emanating from their own families that may interfere with the family therapy process. Supervision can serve to heighten consciousness regarding the interplay of personal and client issues that may impact on the therapeutic relationship and thus on the outcome of intervention.

Satir (1987:21) suggests that in family therapy it is likely that at some point, the therapist will experience a scenario similar to his/her own family-of-origin. Difficulties not yet resolved will impact on the therapy, perhaps leaving the family stranded because the therapist him/herself is lost. In the voiced experiences of fellow family therapy practitioners, the researcher has observed that team members may be affected by similarities to client families relating to life cycle stages of self, children, and even environmental similarities such as schools. In being able to discuss these aspects, consciousness is raised in ways that may be less available in non-reflecting team intervention, and the impact upon the client family and the self can be explored in an empathic setting (the post-family therapy team meeting) that provides a sense of peer support.

Haber (1994:278) specifies some questions to be asked of oneself to explore one's story in relation to the client family. These are:

- Who am I (self and role) in this family? Who am I closest to, more distant from, who seems rigid, who do I feel needs support, who do I want to challenge?
- Where do I fit on the family genogram? i.e. which generation – parent, grandparent, child?
- What is my role in that position?
- When do I occupy more or less of that role during the session?
- Why am I occupying that position? Is it a role from my family-of-origin, pressure from the organisation or referral source? Do I feel compelled to play such a role to keep the family in counselling?
- How do I feel about the role? Energetic, creative, defeated, fearful?

Haber (1994:278-279) believes that the answers to these questions can develop awareness of unacknowledged motivations and choices in our role in the therapeutic encounter. The self can be a consultant to the role, not a supervisor – it can generate information and images, while the role decides whether and how to use the information. The researcher

speculates that answers to these valuable questions may evoke a sense of heightened reflexivity which benefits all participants in the therapeutic encounter.

Aponte and Winter (1987:86) pose the question of how to develop the competency of the "person of the therapist?", in other words, a holistic perspective. Four skills are identified as essential in order to achieve a positive therapeutic outcome: **external skills**, i.e. techniques; **internal skills**, or the personal integration of the self and experience of the therapist which aid effective intervention; **theoretical skills**, i.e. acquiring the conceptual framework needed to guide the therapeutic process; **collaborative skills**, which refers to the ability to coordinate intervention with other professionals to provide the most effective intervention for the client family. The skills resonate in importance for the researcher, being aspects deemed vital in contributing towards effective family intervention.

According to Aponte and Winter (1987:94-96), the therapeutic encounter may prove to be a catalyst for change within the therapist. These authors suggest that in the continuous process of reflection on a client's struggles, the therapist's own inner world cannot remain untouched – personal issues are constantly brought to the fore, requiring resolution. In seeking to improve one's intervention, one's self is improved through the stimulation of awareness, in having the courage to journey into unknown terrain with a client, and thus releasing personal growth and change. The paradox of change is the fact that attention is not focused on the therapist, thus lessening defences, and creating a "…potent indirect passageway to the therapist's psyche…" (Aponte & Winter, 1987:95). Through participation in the developmental process of the client, vicarious change may occur without the therapist being fully aware of it. Thus the process of therapy may generate movement for both client and therapist. However, the successful use of the self requires an elevated awareness of one's personal issues and the impact these could have in an unaware encounter with a client family. The use of one's personal qualities in professional intervention is central in the use of the self in therapy.

In the context of training, Baldwin and Satir (1987:154) suggest that the development of the self is fostered through education, guidance, encouragement and more importantly, through respectful recognition and support. The avoidance of this implies that the self is either insignificant, innate or is so simple or difficult that it must be ignored. A focus on theory, skills and techniques fails to address the issue of the self of the therapist which, according to Baldwin and Satir (1987:155), is elusive and delicate, requiring a non-judgemental environment in which to flourish. These authors stress the importance of a conscious recognition and awareness of the importance of developing and nurturing "…this remarkable therapeutic tool".

For the researcher, the comments of these authors have significance in that, while Family Life Centre is a training setting for family therapy practitioners, the reflecting team process allows for many of these variables to be operationalised, albeit that the self aspect requires more attention. Whether such attention would be through supervision, personal therapy or self-searching is a journey that requires intense contemplation.

Aron and Siegel (1995:127) explore the idea of extra-therapeutic encounters (both real and imagined) as a tool to raise awareness of our reactions to clients. Typically, in the existing literature, references to extra-therapeutic encounters focus on their impact on the client rather than on the therapist. In their findings on a study of therapist reactions to real or imagined chance encounters with clients, valuable information on therapeutic stance, professional persona, attitudes, conflicts and concerns relating to certain clients may be revealed. These authors designed specific exercises that consist of guided fantasies of extra-therapeutic meetings with clients, questions about actual chance meetings with clients, and descriptions of themselves inside and outside the professional setting. Aspects of these exercises include (Aron & Siegel, 1995:136-137):

- Recalling the most uncomfortable actual extra-therapeutic encounter, inner feelings and outward behaviour.
- Consideration of which clients you would **not** like to encounter outside the therapy setting, what would feel uncomfortable? Are there certain clients you would not mind

encountering outside the therapy setting, and what would feel more comfortable about this encounter?

- What places or activities would feel especially uncomfortable or more comfortable?
- How your view of the ideal therapist, clients' view of you and view of yourself in the therapy setting compare?
- Do these comparisons help to illuminate any issues or concerns for you?

These questions strike a chord for the researcher, since the geographic location of Family Life Centre is central to many outlying suburbs, and extra-therapeutic encounters between client family members with different family therapists who live in the surrounding areas seem to occur quite frequently. Consideration of real and imagined encounters could provide important information that may have been below the level of consciousness, but are capable of impacting on the therapeutic encounter.

Karter (2002:115-117) also explores the impact of extra-therapeutic encounters with clients, suggesting that they can evoke overwhelming feelings of anxiety and exposure. A greeting and a brief interchange is suggested as a way of maintaining a form of boundary that offers the client a feeling of safety, and prevents the therapeutic relationship being transformed into a social one. According to Karter (2002:118), the sense of panic that may arise as a result of an unplanned contact may stem from a fear of being seen as an ordinary human being, as well as being seen to be spending the client's money.

For those therapists espousing a psychodynamic approach, knowledge of any personal details of the therapist's life is seen as a block to the development of transferences which are necessary to client growth. On the subject of transference, Rogers (in Baldwin M, 1987b:46) believed the concept to be overrated, that positive or negative feelings towards the therapist are natural and should be allowed to be expressed and explored. In reality, extra-therapeutic encounters do occur and require some consideration of how they will be handled. Karter (2002:118) makes reference to a Tavistock seminar on unplanned contact with clients, the outcome of which was agreement that any unplanned meetings

be acknowledged as soon as possible after the incident. The exact timing is however, crucial – if raised too early the effect of intrusion may be increased; too late may imbue the encounter with other meanings. Should the client bring up the issue, it is suggested by Karter (2002:119) that it be explored in dialogue around the imperfection of therapeutic boundaries and the issue of the therapist being 'human' and thus fallible.

Direct, personal questions from clients can be disconcerting for the therapist and, according to Karter (2002:120) questions relating to counselling experience, or the lack of it, may evoke anxiety for the counsellor. Exploring the clients perhaps unconscious fears that the counselling may prove harmful or inadequate can help to clear the air, and the issue of experience or lack thereof may become less significant. Further questioning from the client on the topic requires an honest response with regard to one's level of experience.

One can respond to the issue of direct questions in an empathic way and assist the client to examine any underlying fears or concerns. However, not every question posed has a hidden meaning – some are just social questions, requiring a brief social response. The issue of self-disclosure is contentious, and while most approaches agree that this may focus attention on the therapist rather than the client, retaining total anonymity and inscrutability is impossible (Karter, 2002:121). Clients discern many clues about the counsellor, from his/her demeanour, the therapeutic interaction, unconscious messages, to the reality of the room in which the encounter takes place. Self-disclosure should only occur if it is for the benefit of the client – Karter (2002:122) suggests that if one is in doubt, refrain.

Fromm (in Karter, 2002:122) states that a direct answer to questions which a client has a right to know and that are on public record (e.g. training, experience, age) is necessary. Questions that are personal in nature require exploration of the interest on the part of the client, or the need to reverse the therapeutic situation and analyse the therapist. Perhaps an issue too, is how comfortable we feel about ourselves as therapists when we are in the spotlight instead of the client.

In conclusion, there are a number of ways in which self-awareness and reflexivity can be enhanced. Typically, supervision, individual therapy and exploration of one's own family-of-origin (or family-of-procreation) may prove useful, in addition to less usual ways such as the visualisation of actual or imagined encounters with clients outside of the therapeutic setting.

4.7 BURNOUT

Berger (1995:303) explores the topic of sustaining the professional self over the career span, stating that little has been researched regarding this issue until recently. Of the studies that are available, a trend relating to dissatisfaction with work, emotional depletion, isolation and burnout are identified consequences of the toll taken by therapeutic work. In addition, Berger (1995:304) cites studies that suggest a negative impact on the personal lives of therapists (i.e. family, friendships, and social functioning) as well as incidences of depression and an increase in suicide risk. An article by Wheelis (in Berger, 1995:304) identifies "…midcareer disillusionment and disappointment …" which may occur as the initial motivation for entering the helping professions becomes frustrated in the process of the therapist developing a realistic understanding of practice. Wheelis observes that it is only in mid-career that one can see the profession clearly – it is after many years of experience, training, emotional and financial investment that one sees in reality what one has chosen. The significance of this statement is obvious and important – it seems to the researcher that with enhanced self-awareness may come a deeper understanding of one's original motives, as well as the evolving realities of practice in the complex field of family therapy.

Contrary to the view that the therapeutic relationship is one-directional with regard to intimacy (as discussed in section 4.3) a study by Berger (1995:307) revealed that the majority of psychotherapists appear to enjoy a real sense of closeness and sharing with their clients, and that satisfaction is derived from the therapeutic relationship. Work satisfaction was reflected in a proactive position, with attention given to variety, balance and the arrangement of professional life in a way that is sustaining. This could involve

designing a work schedule that allows free time, limiting work with client populations who prove difficult to work with on a personal level for a particular therapist, and becoming involved in stimulating opportunities for professional growth (e.g. research, teaching).

Of significance too, is a sense of personal competence and confidence that develops over time and with experience (Berger, 1995:311). The need to 'get it right' and fit actual intervention into a theoretical model can result in anxiety, self-consciousness and rigidity. The development and evolution of an individual style allows greater freedom and spontaneity, and a lessened need for the approval of others. The researcher is of the opinion that the integration of theory with the growing maturity of the therapist facilitates both confidence and humility in practice, and that one becomes more comfortable with uncertainty. This concurs with Berger (1995:312) who states that one comes to understand one's limitations, and accept and respect them, thus lessening self-criticism, pressure and unrealistic expectations. Such a shift implies a loss of idealism that one is able to help everyone encountered in therapeutic settings.

The concept of the wounded healer was explored earlier in this chapter, but in the context of burnout, Miller and Baldwin (1987:149) quote Adler who claimed that healing power is activated within the healer by his or her own wounds, and in a sense the purpose of the wound is to enhance awareness of our own healing power. Thus the healing encounter generates a flow of energy which may be a source of sustenance to the healer. Miller and Baldwin (1987:149) go further, suggesting that the healer who cannot access this profound source is more likely to experience a loss of professional energy and effectiveness, resulting over time in burnout. Denial and repression of one's vulnerabilities and wounds may deprive the therapist of the psychic energy that sustains him/her.

Miller and Baldwin (1987:149-150) hypothesise that burnout will be greater in professionals using problem and technique focused approaches (i.e. cognitive-behavioural or medication oriented solutions used by psychiatrists). According to these

authors, such approaches typify the I-it interaction, whereby subject deals with object, vulnerability is denied and wounded aspects of the self remain unintegrated. In the process of self-discovery and integration of the polarities of the self, creative insight and energy is generated. The importance of conscious awareness and attention to our own vulnerabilities contributes to a sense of wholeness, enabling the client to do the same, thus empowering the healer in both client and therapist.

Karter (2002:52-54) explores various aspects relating to burnout, quoting Storr who states that it is essential for the therapist to find some area of self-expression to ameliorate the sense of becoming a non-person through living vicariously through one's clients. Maintaining a life outside of the therapeutic world is vital to minimise stress and burnout, and this involves keeping up relationships with family and friends, taking holiday breaks, and engaging in physical exercise. On a more subtle but insidious level, Karter (2002:23) refers to a theme of experienced therapists feeling under "…psychological attack..." by the more disturbed client, resulting in serious damage to health and well-being. According to Asay and Lambert (1999:44), when therapists become fatigued or experience burnout, the first skill that suffers is the ability to empathise with clients and express warmth and acceptance. Given the significance of the therapeutic relationship, a deterioration of relationship skills will impact on therapeutic effectiveness, but may provide the practitioner with a warning of impending burnout, thus illuminating the necessity of making changes.

Grosch and Olsen (1995:275) state that working long hours has become a "…badge of honor…" among certain professions. Along with the complaints is a sense of pride and importance that justifies avoidance and indulgence in other areas of life, and according to these authors this is most prevalent in the helping professions. A combination of environmental, work and personal circumstances may result in the experience of burnout and stress, which according to Grosch and Olsen (1995:275), is reaching epidemic proportions. Obvious and simplistic preventative suggestions such as balancing work and play, exercise, hobbies and so on, leave people feeling guilty and frustrated if attempts are not made or are inadequately carried through.

According to Grosch and Olsen (1995:275), a theory of burnout prevention must consider the personality issues of the individual, the complexities of the mental health system and one's position in it, and ways of finding meaning and balance in life. Aspects relating to prevention of burnout focus on self-assessment; investigation of the impact of the family-of-origin; understanding of own narcissistic issues; the use of support groups and effective supervision; and, finding balance in life (Grosch & Olsen, 1995:276-286).

- **Self-assessment**

According to Grosch and Olsen (1995:276), self-assessment must take place on several levels. Firstly, those in the helping professions need to assess their experience in various areas of their lives. This includes questioning one's experience of enjoyment and satisfaction at work, such as feelings of enthusiasm and optimism, and being sensitive to feelings of dread, boredom, tiredness and pessimism about the future. It includes being aware of fantasies about a new position, or even a new career. Assessment also includes looking at the balance of one's activities, reflecting on whether they are one-dimensional and relate mainly to professional life. In addition, assessment involves looking at one's family life and the experience of oneself by spouse and children. Grosch and Olsen (1995:276-277) suggest "…cross-training…" which refers to varying one's work to alleviate early symptoms of burnout. Ongoing tiredness, flatness and boredom suggest that burnout is more advanced, but it is difficult to distinguish between burnout and tiredness. While a holiday may rejuvenate the practitioner, the sense of ennui that comes with burnout does not disappear after a holiday, and requires further assessment as outlined below. Rogers (in Baldwin M, 1987b:46) states that the therapist has the right to give, but not become worn out by giving, and that therapists have differing levels of tolerance with regard to giving.

- **Family-of-origin work**

In the experience of burnout, the therapist tends to focus on her exhaustion, sense of disillusionment with work, and the stresses of home life, and according to Grosch and Olsen (1995:277-278), one's family-of-origin seems unrelated to the primary problem. However, these authors suggest that the "…imprint…" of our families creates roles,

patterns and expectations that are played out in the arena of marriage and of work. A lack of understanding and resolution of these aspects may result in becoming trapped in self-defeating approaches to love and work. Berger (1995:314), on the other hand, found that the sense of commitment to one's work in the therapeutic field, which can be traced back to significant experiences in the family-of-origin, provides the raw material for professional growth. In common with the views of Grosch and Olsen however, Berger (1995:314-315) also believes that both positive and negative family experiences have a profound impact on an interest in psychotherapeutic practice – they can provide motivation, a sense of purpose, and contribute to the development of compassion and sensitivity, as well as attitudes and beliefs regarding helping others. The issue for the researcher here however, is the capacity for self-awareness so that any influences, be they positive or negative, are brought into conscious awareness to lessen their impact on an unconscious level within the therapeutic encounter.

On a personal level, the outcome of Berger's study was his own exploration on a deeper level, of the impact of his family-of-origin upon his career choice, and the realisation that many of his stressors and frustrations regarding his work were paralleled in the dynamics of his earlier family life. While family-of-origin issues remain relevant to professional practice, the sense of perpetuating long assigned family roles needs resolution (Berger, 1995:316-317). Duhl (1987:74-75) too suggests the significance of knowing the systems within the self, being aware of one's thinking and beliefs relating to the stages of life, exploring the myths, rules and stories of one's own family and others in order to become aware of how we get hooked into certain scenarios and thus become reactive.

A genogram can facilitate exploration of relevant themes which may pertain to one's work – e.g. conflict, assertiveness, the value of work versus play, perfectionism. In addition, one's role in the family-of-origin is significant – e.g. the 'successful' one, the parent substitute, over- and under-functioning which translates into one's work ethos. Insight into how these roles and patterns are replicated in the work environment is a step towards the prevention of burnout. A lack of differentiation from one's family-of-origin may interfere with the ability to set boundaries and be assertive in the work environment.

According to Grosch and Olsen (1995:281), knowledge of family systems and dynamics does **not** mean that the practitioner has achieved a measure of differentiation from her own family-of-origin. This view highlights the necessity of knowing the self in conjunction with one's chosen theoretical approach – the latter without the former is insufficient and potentially harmful.

- **Assessing the cohesiveness of the self**

Grosch and Olsen (1995:282) suggest that the practitioner needs to assess the fundamental need for appreciation and the desire to be liked and admired. The paradox of professional burnout is that the need to help may be motivated by the need to **be** loved, rather than to give it. As long as we can secure positive feedback, attention and admiration for hard work, even overwork which is often rewarded, we risk burnout. Gratification of our self-esteem can lead to emotional entanglements with clients, which can result in the abuse of power in the therapeutic relationship. Historically, Freud recognised the power of the therapist, and developed the idea of mandatory analysis for all psychotherapists to understand and deal with their own conflicts and neuroses (Satir, 1987:19). Grosch and Olsen (1995:282) believe that in order to find balance in love and work we need to accept our own need for appreciation and admiration. Personal therapy and/or peer support groups may be a way to come to terms with our narcissistic vulnerability. Awareness of our narcissistic needs may mean we are less likely to overwork to fulfil these needs. Merry (2002:163) also discusses a number of advantages relating to personal counselling for the counsellor, focusing on the importance of the experience of being a client, as well as the opportunity to experience first hand the approach in which one has been trained. The researcher speculates that this may consolidate the feeling of 'fit' with one's chosen approach, or may even give the therapist cause to question such a fit. In addition, if the experience of therapy is from an alternative perspective, curiosity may be evoked to learn more about different theories. Merry (2002:164) states however, that no clear evidence exists to support the view that personal counselling results in one being a more effective counsellor.

- **Support groups for mental health professionals**

According to Grosch and Olsen (1995:283), a professional support group is an excellent way in which to deal with the issues of differentiation and unmet needs. Such a group must be structured to ensure trust, confidence to explore issues (personal and relating to the work environment), and confidentiality, and should be outside of the primary work setting. Berger (1995:308) mentions the importance of support systems to sustain energy and vitality. This entails not only formal support, as mentioned by Grosch and Olsen, but also informal support with friends and colleagues. Berger (1995:309-310) believes that with peer support, the boundaries between the personal and professional life of the therapist become blurred, resulting in the whole person (intellectual and emotional) being nourished and replenished in the supportive relationship. In addition, the experience of isolation is lessened, while validation and appreciation enhance personal and professional growth. In the opinion of the researcher, the latter point may reduce the dangers of one's narcissistic needs coming to the fore in the therapeutic encounter.

- **Supervision**

Effective supervision is a way to prevent burnout, and according to Grosch and Olsen (1995:284), supervision should take place outside the work setting, have no evaluative function and provide a theoretical orientation that is suited to that espoused by the supervisee. While cost may be a consideration, the benefits in terms of growth and burnout prevention are far outweighed. However, according to Merry (2002:172), the experience of supervision may prove to be mixed, some of it helpful, some not. An atmosphere of being policed, judged or 'fixed' is not conducive to growth and learning, while being supported and encouraged by a knowledgeable mentor is extremely valuable. Supervision groups can also help to reduce the financial commitment and increase the ability to work effectively and with more confidence. Peer supervision groups can also be growth-enhancing through creative input from colleagues. According to Merry (2002:182), peer supervision is more suitable for relatively experienced counsellors, or to supplement individual supervision. Advantages include support, encouragement and learning from the experiences of colleagues – disadvantages may be that less confident or less open therapists may be unwilling to explore cases, and hide within the group context.

Merry (2002:183) also mentions facilitated group supervision where an experienced counsellor provides supervision for a group of counsellors who take turns to present a case, and co-supervision wherein two counsellors supervise one another. This latter type of supervision is deemed best suited to experienced counsellors or to less experienced ones as a supplement to other forms of supervision. Dangers of co-supervision include difficulties if both counsellors work within the same organisation, as work relationships may impinge on counselling work and the supervision may be unchallenging if the relationship is too familiar (Merry, 2002:183-184). Berger (1995:310) states in his research conclusions that satisfied therapists were committed to their support systems, which function to enhance personal relationships and emotional health.

- **Finding balance**

Balancing love, work and play without attending to the above-mentioned issues, will prove difficult (Grosch and Olsen, 1995:285). Balance includes taking care of primary relationships as well as physical, emotional and spiritual needs. Berger (1995:319) believes that therapeutic work does not get easier over time. While skill and experience increase, the degree of difficulty in the psychosocial sense does not lessen. Therapeutic work is difficult on a daily basis and the necessity of learning to care for and sustain oneself over time impacts both our own lives and on the quality of our work.

In conclusion, exploring family-of-origin issues, differentiation of self and healthy narcissism can be part of the prevention of burnout. Effective supervision and finding a balance in one's life are ways of enhancing professional growth.

4.8 SUMMARY

The development of the self of the therapist is a continuous and ongoing process, easily relegated to the back-burner in the routine of daily life and work. The consequences of such neglect are unfortunate, and potentially destructive for the client family. A vibrant and alive self is a source of energy and creativity, one that benefits the therapeutic process, as well as the therapist him/herself.

In this chapter of the literature review, the concept of the self was explored, in terms of the connectedness of the self in interpersonal relationships as well as optimal human development on a personal, and hence professional level. Motivations and ideals relating to therapeutic work were explored as part of the process of enhancing self- awareness.

The relationship between the self and one's chosen theory is significant when considering the importance of authenticity in practice. Thus, the embodiment of theory was explored to raise awareness of the importance of knowing why a particular theory fits with the self of the therapist, and its impact on the therapeutic relationship. The notion of the therapeutic relationship is an essential aspect of the therapeutic encounter, transcending the mere use of skills and techniques which may become mechanical if the relationship is neglected. It is vital for the therapist to consider and evaluate his/her role, and thus the perceptions of clients were considered in terms of how to render practice more user-friendly.

The development of self-awareness and reflexivity is an ongoing and important task and certain suggestions from the literature were considered as a way of enhancing this process. An exploration of issues relating to burnout was undertaken, consideration of which may provide an opportunity to enable the therapist to become more realistic in her expectations, and augment the ability to take care of the self over the course of the therapeutic career.

The following chapter explores the findings of the study, linking them to the relevant literature as discussed.

CHAPTER 5

QUALITATIVE RESEARCH FINDINGS

5.1 INTRODUCTION

Qualitative studies are exploratory and discovery orientated, and thus by implication one can never be sure which direction the journey into data analysis will take. The shift from a positivist research framework which aims to describe, perhaps explain and predict the 'truth' has led to studies that aim to capture the meanings participants give to the aspects of their lives under study, with the role of the researcher as co-creator of meaning gradually evolving (Henning *et al.,* 2004:19-20). These authors suggest that the interpretivist framework views observation as fallible, open to error, and theory as revisable. Multiple perspectives are sought to explain a phenomenon and reality is "…imperfectly grasped…" because the views and beliefs of human beings are subjective and biased.

In this chapter the research methodology used by the researcher will be reviewed, as will data collection, data processing, data analysis and data interpretation. The qualitative research findings will be analysed and interpreted in terms of the findings and with reference to the literature review.

5.2 RESEARCH METHODOLOGY

A qualitative research design was used as the method of capturing the meanings of respondents with regard to the phenomenon under study. The purpose of the research was exploratory, the intention being to explore the implications of epistemological shifts in the field of family therapy and thus on the practice of family therapy within the South African context. An exploratory study aims to explore a little-known research area in

order to gain insight into phenomena. The goal of the study was to explore the perceptions, opinions and experiences of practitioners with regard to epistemological shifts in the field of family therapy, reflecting team practice, and the development of the personal and professional self.

In a qualitative study the initial research questions start out broadly, becoming more focused during the research process, thus allowing for flexibility to explore the phenomenon in depth. The research questions focused on epistemological shifts; the implications of such shifts and enhanced theoretical knowledge on the development of a reflexive, authentic self; experiential training and the development of an approach that is authentic to the self; and, the implications of the development of reflexivity and authenticity in relation to competence and confidence in the practice of family therapy.

A phenomenological strategy enabled the researcher to gain an understanding of the idiosyncratic perceptions, opinions and experiences relevant to the themes explored in the interviews. The interview schedule itself was semi-structured, with a number topics and questions relating to the themes under exploration, and was used as a guide to generate data.

The study itself was applied research, specifically knowledge utilisation (KU) as identified by Rothman and Thomas (1994:3-4). This type of research aims to extend knowledge of human behaviour in relation to intervention in practice, in this case, the practice of family therapy.

5.3 DATA COLLECTION, PROCESSING, ANALYSING AND INTERPRETATION

According to Fouche (2002:106), a qualitative study explores a topic in the narrative form. The phenomenological interview aims to produce data on the experiences, perceptions and opinions of respondents, with the content seen as the 'real' meaning of subjective experience (Henning *et al.,* 2004:53).

According to Henning *et al.* (2004:57), the researcher who interviews the respondents co-constructs the meaning (i.e. data), whether intended or not. The utterance of a word of encouragement, or even non-verbal encouragement suggests interest in a line of thought and the wish to pursue it – thus there is dialogical communication. Redirection of the interview by the researcher may result in missed or lost information. A semi-structured interview schedule encompassing the themes relevant to the study was used by the researcher as a guide to generate narratives for data collection. The use of interviewing skills allowed for probing and clarification, the aim being to enhance the range and depth of responses. Such interviewing or communication skills include listening to the nuances of the respondent's narratives, observing non-verbal behaviour and vocal expression. During the interviews the researcher attempted to facilitate a process wherein the respondents could reflect on the themes and explore the subjective meanings these had for them – every effort was made to avoid 'leading' the respondent in a certain direction, while remaining attentive to the self-reflective narratives that form the basis of the topic under study. It is probable however, that a total avoidance of leading respondents would be an impossible undertaking, especially since the respondents themselves, are trained observers of human behaviour (in this case, the researcher's).

An audio tape recorder was used to capture verbatim data, and transcripts of the interviews were undertaken as soon as possible thereafter. According to Henning *et al.* (2004:76), the transcriptions of the conversations should be undertaken timeously and preferably personally by the researcher/interviewer. This allows for meanings relating to tone of voice, volume, punctuation, and so on to be considered in context. In addition, transcripts should not be viewed in isolation as merely text – the researcher must bear in mind the process of the interview and other contextual data. Alone, the verbatim transcript (content analysis) may lead to naïvely realistic interpretations and hence, findings, with data that yields a 'thin description' of facts and circumstances (Henning *et al.,* 2004:77). All of the transcripts were personally undertaken by the researcher, and aspects such as those mentioned above, (i.e. tone, volume) were noted in the written transcripts. The hope was to gain a 'thick' description of the themes being explored.

Respondents in the study were either social workers, psychologists or interns employed at Family Life Centre in various capacities, i.e. staff members, sessional workers, or undergoing an internship year as a component of study. Appointments for the interviews were made with each individual and the face-to-face interviews took place at their convenience, either in a private office at Family Life Centre, or in a few cases, in the respondent's home.

With regard to the interview itself, Henning *et al.* (2004:75) suggest that while the provision of the interview schedule for perusal by the respondent may be useful to reflect on, it may pre-empt certain responses or create a degree of tension that may block conversation. The researcher decided to use the interview schedule without prior viewing by respondents, since authenticity and spontaneity of responses were essential to capture the meanings of respondents with regard to the phenomena in question.

According to Henning *et al.* (2004:57), respondents may take on the role of 'ideal interviewee', perhaps feeling the need to display competence in doing the interview. In addition, the process of interviewing gives rise to a type of interaction that is not completely neutral, and the issue of asymmetrical relationships arise. Henning *et al.* (2004:58) suggest that more literate and critical respondents would possibly be less open and forthcoming with their innermost feelings and experiences, perhaps even circumventing the purpose of the interview. In this study all of the respondents were colleagues in the field of family therapy, professionals who understand the research process to some degree and who could thus be viewed as having the potential to be wary of the interview, or to attempt to be the perfect respondent. In fact, the researcher experienced the opposite response, with the openness, genuineness and forthrightness of the respondents to the interview proving to be an encounter that was both remarkable and humbling.

Henning *et al.* (2004:66-67) suggest that the relationship between respondent and interviewer is significant, and that unequal power dynamics come into play. A planned interview is not a free, naturally occurring conversation, rather it is contrived requiring a

degree of direction or focus. This may result in data that is merely information, as opposed to the sharing of knowledge making. The feeling of being on "…an information production line…" can result in respondents feeling violated with regard to the summarised interpretations of their responses, with a different focus and meaning other than intended (Henning *et al.,* 2004:67). In contemplating a more symmetrical position between interviewer and interviewee, Henning *et al.* (2004:69) suggest that while the discussion remains contrived to an extent, the contribution of the respondent is honoured as part of the knowledge making process. The researcher fervently believes that the nature of the relationships between researcher and respondents is egalitarian, with a shared sense of purpose towards the enhancement of knowledge with regard to the practice of family therapy at Family Life Centre. For the researcher, there was a real sense of the respondents being eager and wanting to contribute to this goal. With regard to the issue of feeling disrespected in the summarised interpretations of responses, the researcher made every effort to provide an authentic account of the experiences, perceptions and opinions of the respondents. Since the topic under study sought to reflect the experiential reality of the respondents, rather than seeking the 'truth', the researcher hopes that justice has been done to the meanings of their very genuine and heartfelt responses.

Qualitative data analysis involves an integration of the data collection and data analysis phases, and may necessitate revisions to the collection and analysis of the data (De Vos, 2002b:341). According to Henning *et al.* (2004:101), the real test of competent qualitative research lies in the analysis of the data, a process that requires careful analysis and the ability to capture an understanding of the data in written form. Qualitative content analysis is a basic method of working with data where the initial transcript sets out the data to form an overall impression, after which units of meaning (sentences or phrases) are marked out and grouped together, a process involving open coding (Henning *et al.,* 2004:104). Open coding is an inductive process, wherein data are selected and labelled according to meanings and themes. It is however, necessary to have an overview of as much contextual data as possible. Once all the data has been coded and categorised an important task is "…seeing the whole" (Henning *et al.,* 2004:106).

This involves a number of questions, including: the relationships in meaning between the categories; what the categories say and do not say; how they address the research question; how the categories link with what is already known about the topic; issues in the foreground and in the background.

For the researcher, the open coding process involved reading through the transcripts, highlighting words, phrases and themes in order to search for patterns of experiences, events, beliefs and interactions that are common to the study, i.e. universals. In addition, differences of experience and meaning are significant in a phenomenological study and must thus be noted. The themes were classified into categories and subcategories of meaning, which may reflect the subjectivity of the respondents experience through contradiction, ambiguity and inconsistency. Themes which represent a segment of the research question were used as the basis for discussion and argument.

Intersubjectivity refers to people sharing the same view in their response to a particular issue or aspect (Henning *et al.,* 2004:52). With a number of interviews involving different respondents there may be more and more reliability of data, i.e. intersubjectivity, and thus a shared understanding of an aspect or aspects may be achieved. Such shared aspects form the basis for insight into the impact of the self on the practice of family therapy, and hence provide a discussion that may be of use to present and future family therapy practitioners at Family Life Centre. Discursive interpretation looks for meaning beyond the superficial and the obvious (Henning *et al.,* 2004:65). It is a way to look at the meaning a phenomenon holds for the respondent, on a content level as well as on an emotional level.

In the section that follows the findings of the study are presented in text, verbatim for the most part, to illustrate the subjective meanings of respondents.

5.4 QUALITATIVE RESEARCH FINDINGS

The qualitative research findings will be discussed in the section that follows. Data will be interpreted in terms of the relevant findings, and with reference to the literature review. The findings discussed below pertain to a total of nine (9) qualitative interviews, one with each respondent. The duration of the interviews ranged between 1hour 40 minutes and 2 hours 10 minutes. To facilitate a sense of coherence for the reader, the findings are structured according to the format of the interview schedule.

NB: The number of respondents is nine; however the number of responses may differ in the various categorised findings. At times, respondents answered more or less on various themes, thus the researcher grouped together certain aspects that seem to best reflect elements pertinent to the study. Thus the number of responses may exceed or occasionally be less than the number of respondents.

5.4.1 Biographic Details

The biographic details of the respondents are discussed in the section that follows.

Total number of qualitative respondents: N = 9.

- **Gender:**

Female = 9

In the study, all of the respondents are female. As stated by Collier (1987:53) in the literature review (Chapter 4:205), the majority of family therapy practitioners are women, a factor which requires contemplation of the experience of family therapy for the client family, as well as for the family therapist. Gender socialisation has, according to Hare-Mustin (1994:21) impacted on the perpetuation of dominant discourses of patriarchy and inequality for both males and females, requiring, in the opinion of the researcher, a large degree of self-awareness on the part of the family therapy practitioner regarding beliefs and values around issues of power and patriarchy. Collier (1987:52) states that

differences in the socialisation of males and females require a careful and disciplined use of the self.

- **Present marital status:**

With one exception, a respondent who is engaged to be married, all of the respondents are married with children. One respondent, currently on maternity leave, was childless during the period of her experience of family therapy practice.

- **Age:**

The age of the respondents ranges from 27 to 57 years of age. The majority of respondents are in their 30s and 40s.

- **Level of experience as a family therapy practitioner:**

In Chapter 1 (point 1.9.3) the levels of experience as a family therapist were categorised into three sections for the purpose of the study, i.e. little experience (6-12 months); moderate experience (12 months – 4 years); extensive experience (4 years +). The 9 respondents interviewed are categorised as follows:

Little experience: N = 4

Moderate experience: N = 2

Extensive experience: N = 3.

Age and level of experience as a family therapy practitioner were not necessarily correlated, as the youngest respondent falls into the category of extensive experience while both of the respondents in the 'moderate experience' are more mature in years. Of the respondents falling into the category of extensive experience, the most experienced family therapist has practiced this method of intervention for 6 years. The least experienced family therapist has seven months experience.

From the findings it transpires that none of the respondents were in family therapy practice in the decade of the 1980s, a period of prodigious growth in the field (Gladding, 2002:74; Goldenberg & Goldenberg, 1996:100). It was in this period that questions began to be raised concerning theory, practice and research in family therapy, with

criticism focused on techniques, terminology and first-order cybernetic views. Thus it may be assumed that the filtering into consciousness of epistemological shifts in thinking about the family system has **not** been part of the experience of this sample of family therapists. The respondents in this study with the most experience in family therapy had four to six years practice experience, thus excluding any of the respondents from having experienced first-hand, the criticisms and advances of the decades of the 1980s and 1990s. Thus, knowledge of the shifts would be primarily theoretical, rather than experiential. Further exploration in the study will reveal how this may or may not have impacted on their understanding of the epistemological shift in the family therapy arena.

As mentioned in the literature review (Chapter 2:57), Family Life Centre ventured into the field of family therapy in the decade of the 1970s (Meyerowitz, 2006). However, none of the early pioneers of that era remain in family therapy practice, although Mrs. Jackie Meyerowitz remains an integral part of the organisation, albeit in a different division (divorce mediation). Geurin and Chabot (in Carlson & Kjos, 2002:156) speculate on the future of family therapy as the pioneers make way for a new generation of practitioners, seeing the growth of family therapy in the integration of interventions that will facilitate the growth of the individual and the family.

- **Position held at Family Life Centre:** (i.e. staff member, sessional worker, intern)

Three respondents are staff members at Family Life Centre, two of whom where originally social work interns at the organisation prior to qualifying. One respondent was a staff member (as a social worker) and subsequently went on to study to be a psychologist, thus working during her internship as a family therapist and currently as a sessional worker. One respondent was a psychology intern, while another respondent was a social work intern – both are currently working as sessional workers. One respondent was a psychology intern (D. Psych) and is currently working as a sessional worker while the final two respondents are interns, one in psychology (MA), one in social work (MA).

- **Tertiary education:** (including degree in progress, if applicable)
- **University/universities from which degree/degrees were obtained:**

The tertiary education of the respondents and universities from which their degrees were or are currently being obtained varied, and are as follows:

Respondent 1: BA(SW) (Hons.); MA (Forced Migration); MA (Public Health) University of Witwatersrand.

Respondent 2: BA (SW) (Hons.) University of Witwatersrand.

Respondent 3: B(SC) University of Cape Town; BA(SS) (Hons.); MA(SS) University of South Africa.

Respondent 4: BA (SW) (Hons.) University of Natal; BA (Psych. Hons.) University of South Africa; MA (Educ. Psych.) University of Witwatersrand.

Respondent 5: Dipl. (Nursing) BG Alexander College of Nursing; BA(SS) (Hons.) University of South Africa.

Respondent 6: BA (Education) University of Witwatersrand; BA (Psych. Hons.) University of South Africa; MA (Educ. Psych.) University of Zululand.

Respondent 7: BA (Art) University of Hallan, Sheffield; BA (Psych. Hons.) University of South Africa. MA/D.Psych. University of Johannesburg.

Respondent 8: BA University of Cape Town; BA (Psych. Hons.); MA (Educ. Psych.) University of Johannesburg.

Respondent 9: BA (SW) (Hons.) University of Port Elizabeth; MA(SW) Nelson Mandela Metropolitan University (formerly University of Port Elizabeth).

In the literature review (Chapter 2:53) it was identified that the three disciplines identified mostly regarding involvement in the family therapy arena are psychiatry, psychology and social work (Carr, 2000:51; Goldenberg & Goldenberg, 1996:96). While there are no psychiatrists involved with family therapy at Family Life Centre (although referrals are made on occasion), the findings show that the other two disciplines are well

represented. The majority of practitioners (in family counselling, as well as individual and couple work) at Family Life Centre are social workers, a profession which Goldenberg and Goldenberg (1996:100) state can be viewed as the originator of family intervention. This view is shared by Carr (2000:51) who identifies social work as being "… historically privileged …" in identifying the importance of working with the family.

- **Counselling history:** (professional and non-professional, if applicable)

The counselling history of the respondents shows much variety. Undergraduate social work training involves extensive practical counselling training, and several of the respondents have done this component of their training at Family Life Centre, initially as students and once qualified, as sessional workers or staff members. Psychology students undertake an internship year at various organisations, including Family Life Centre, where they gain practical counselling experience. They too, often remain at Family Life Centre after completing their internship, usually as sessional workers. Other counselling experiences of the respondents involved organisations such as Life Line, Telefriend, Hospice, JAFTA, Child Welfare, Jewish Community Services, JHB Parent and Child Counselling Centre, The Children's Foundation, Gateway, Emanna Trust, Leeukop Prison, and Khulisa Management Services, as well as private practice, school counselling and church counselling.

- **Other work experience:**

As with counselling experience, the variation in the respondent's additional work experience is extensive. Experiences include: nursing, teaching, medical research, consulting, corporate training/other training, events management, psychometric testing, information technology, hairdressing, sales/marketing, human resources, and, bookkeeping. From the findings it can be seen that the respondents have a rich and varied history of work experience and activities, all of which contribute in many ways to the enrichment of the personal and professional self.

The themes for discussion that follow were presented to the respondents in the order that they appear on the interview schedule. However the categories of information are not

discrete, and there is much blending and blurring with regard to the data obtained. While the researcher will attempt, for clarity, to keep the themes reasonably clear, to overly dissect the responses for the sake of categorisation is an unnecessary task, and one that seems disrespectful to the integrity of the respondent's explorations.

5.4.2 Perceptions, Opinions and Experiences relating to Family Therapy Theory and Intervention

The ensuing themes explore the perceptions, opinions and experiences of the respondents with regard to theory and intervention.

5.4.2.1 Family therapy theory

- **Opinions regarding the epistemological shift in the field of family therapy:**

An exploration of her own shift from the cybernetic view of family therapy to a social constructionist perspective was shared by Hoffman (1990:11), who believes that family therapists can only profit from the epistemological revolution that has occurred in the field, emphasising the art of language. Mills and Sprenkle (1995:375) share an appreciation of the personal meanings that evolve through language, believing this to be more appropriate to contemporary values. As mentioned above, the respondents in this study were not in family therapy practice during the period of critique and questioning of first-order cybernetics (i.e. the 1980s) and the move to eclecticism and integration (i.e. the 1990s). It seems that formal studies tend to touch quite lightly on family therapy theory, particularly its history and evolution, and the onus rests with the individual to make a more in-depth foray into the theoretical material. Two of the respondents feel that they are too inexperienced to have a real opinion regarding the epistemological shift that has occurred in the family therapy arena over the past decade, as the statements below testify.

"I can't say that I've lived through the shift ... I'm early days yet".

This suggests that the potential impact of the shift is less for family therapists new to the field. The debates and critiques of the period of the epistemological shift may seem to be of historical interest, impinging less on personal experience.

From her reading on the topic of the postmodern shift, but without the experience of it in practice, another 'inexperienced' respondent believes that it is a *"...move with societal trends ... a process of growth in the field"*.

A number of the respondents were initially unsure of the distinction between the categories of modern and postmodern theories, but did have an understanding of the different theories when mentioned by the researcher, i.e. strategic, structural, versus narrative, constructivist. Perhaps this uncertainty highlights the researcher's experience at Family Life Centre, of an insufficiently comprehensive theoretical orientation that consolidates and deepens critical understanding of the approaches and shifts in the field of family therapy. In addition, not having been in practice is the decades of growth and challenge in family therapy theory may also impact on a clear understanding of the different paradigms. According to Auwerswald (1987:322), confusion has resulted from a failure to differentiate between modern and postmodern paradigms.

One respondent believes the distinction to be an issue of a shift in power.
"From my perspective ... the client ... the system will certainly hold more of the power ... and a more kind of equalised power ... and I prefer that. Although! ... I do think that certain interventions from the modernist era are applicable".

The issue of power and the expert role was also mentioned by other respondents who believe that the shift focuses attention on the following aspects.

"... where the client is taking you, and not so much on an expert coming in to dictate ... it's a more, uh, connecting way of working with families and um, its ... client-focused".

"... you're no longer the expert with a normative understanding of how the family should be and should relate ... so it's not about pathologising any individual, it's not about pathologising those relationships, but considering alternatives and breaking stuck patterns of relationships".

"I actually prefer a, um, a shift towards postmodernism because it's not so instructive, authoritarian, top-down ... rather than the therapist having an idea of where they want to push the family ...".

It appears from the verbatim statements above, that the respondents feel a sense of discomfort with the expert role, thus implying an orientation towards a postmodern position. If one considers the views of Carr (2000:122) and Goldenberg and Goldenberg (1996:304) as outlined in the literature review (Chapter 2:86), the role of the practitioner in constructivist family therapy is that of collaborator of the family's personal construct systems, as well as facilitator of an exploration of the constructs and ways of revising them. The expertise of the family therapy practitioner lies in her role as facilitator of a process, and not as director. A collaborative, non-hierarchical role privileges the perspective of the family as much as that of the therapist.

Linking with this perspective, one respondent believes that with the change in role of the family therapist to that of facilitator assists the process in the following way.
"... being open to the uniqueness of that family and how they relate but nevertheless understanding where they could be, um, where their relationships and their patterns of relating becomes the source of the problem".

The imposing of a theoretical frame of reference onto a family is viewed by one respondent as unhelpful to the process, whereas a postmodern approach *"... reverses the process"* and is *"...an exploratory expedition into their world"* in an effort to understand their reality.

This perspective links with the discussion in the literature review (Chapter 2) in which postmodern implications for family therapy were explored. According to Gergen (in Carr, 2000:119), certain problems and contexts lend themselves to particular models, requiring a consideration of many variables (e.g. gender, class, culture) since there exist no universal principles for effective practice. Thus, understanding the worldview of the family and exploring their reality is essential. In addition, according to Pocock (in Rivett & Street, 2003:49), the crucial issue is which model is appropriate and useful to a particular family at a particular time, as well as consideration of the fit of this model with the individual practitioner.

One respondent feels that in the shift to postmodern thinking, the process of family therapy is facilitated in the following way.
"... sometimes ... to focus more on the narrative than on a structural/strategic outcome ... because ... when you are very strategic you maybe get lost in the ... you lose part of the process because you're not focusing enough on the narrative and in some way ... you could possibly say it predefines what you want as the outcome".

This statement illustrates a postmodern orientation in that it links with the view of Bertrando (2000:88) who states that the original cybernetic position is seen as mechanistic, although this was not the intention of Bateson, but merely an analogy to computer metaphors. In addition, the issue of a single objective reality is modernist in its assumptions, and the respondent perhaps implies that this would lead to a pre-judging of the outcome to be achieved. However, as stated by Kvale (1992:200) (in Chapter 2:83) the distinction regarding the modern/postmodern divide is an unnecessary polarity. Rather it is a re-conceptualisation of subject matter, opening up new avenues for social science.

Some of the respondents seemed more confident regarding their theoretical knowledge and held firm views on the epistemological shift in family therapy theory.

"... from my understanding family therapy falls very nicely under the meta-theory of ecosystemic understanding of the inter-relationships and patterns of relating within the family…".

"... I think from a theoretical perspective its given more scope ... more flexibility in working with the family and working in the here-and-now, not only working in the past ... and more opportunities for exploration…" providing a broader understanding of family relationships that is *"... less rigid ...".*

The overall finding of this discussion with the respondents is that the epistemological shift in family therapy theory benefits the process of intervention and practice.

"... I would say it's a welcome shift".

"... its necessary ... the shift to openness is a good one".

"... I think the shift going from the strategic and structural model to the more constructivist model is, um, a positive one ...".

Thus despite, for some, there being a sense of inexperience or a lack of certainty regarding what constitutes a modern and postmodern distinction, all of the respondents view the changes as positive in terms of theoretical growth and the move from the expert role to one that is more collaborative.

- **Theoretical approaches:**

According to Baldwin and Satir (1987:153), practitioners are representatives of their chosen theories and while little, if any evidence exits to indicate the superiority of one theoretical model over another, many complex variables are present in the therapeutic encounter that impact on client outcomes. In the literature review (Chapter 2:40), Goldenberg and Goldenberg (1996:16) state that while most family therapists subscribe to a cybernetic epistemology, a schism exists between those operating from a modernist

perspective of objectivity and change from outside the system, i.e. first-order cybernetics and those who see the family therapist as part of the system and who participate in the construction of a new reality, in other words a second-order cybernetic view.

The former part of this statement seems to be an accurate reflection of the opinions of the majority of respondents, although whether a 'schism' exists between team members favouring a different approach remains to be explored. The impact of training, both at university level and at Family Life Centre, is evident in the responses below.

One respondent referred to her training at university as stemming from a humanistic, person-centred approach, which reflects in her way of working with the family.
"... being family-centred ... the basis being PCA".
However, this respondent also feels a need to become more eclectic as she develops and becomes more experienced in family therapy.
"... I want to build on that...".

Seven of the nine respondents identified either a first- or second-order cybernetic paradigm as the approach used in the practice of family therapy, although the distinction between the paradigms was not always made.

"At Family Life Centre, definitely more the narrative ... but that's because that's the culture of the place ...".

"Well, the reflecting team (Tom Andersen's approach) *... um, is the norm at Family Life Centre...".*

"I think, falling under (supervisor) *... as an intern I had to take on ... well, she's not very prescriptive, she's very open and free but ... we were given readings on the narrative approach, Michael White's approach to family therapy, so it introduced that to me ...".*

"I think some of its narrative but coming from more of a kind of community development background (at Family Life Centre) *... also quite systemic ... I think you have to look at the way things work together and how things happen, you can't have a situation where you're looking at one person in isolation and naming them as the problem ...".*

"We were shown Minuchin at varsity and then that's pretty much what we did here (at Family Life Centre) *... that was my first practical experience of family therapy ... they kind of fitted together".*

The comments above highlight the influence upon the family therapy practitioner of the approach used by the organisation. Of particular significance is the fact that with inexperience, comes a degree of acceptance of the paradigm of the organisation or supervisor within the organisation, perhaps without much questioning. In the literature review (Chapter 4:223), Keith (1987:61) states that the self of the therapist may become clouded by theory and training, thus inhibiting spontaneous behaviour and thought. Following a similar train of thought, Goldenberg and Goldenberg (1996:365) suggest that in the process of learning from more experienced colleagues, there is a risk that over-dependency on the direction of others may inhibit the unique self that each therapist brings to the therapeutic encounter. Spinelli and Marshall (2001:2) state that most therapists can directly answer the question of their chosen theoretical approach, but what is seldom considered is how these theories have been interpreted and re-interpreted from an "…embodied standpoint".

Also important is the fact that while most of the respondents identify the narrative approach as being used almost exclusively at Family Life Centre, one respondent felt that the work of Minuchin (i.e. structural family therapy) is the standard approach.

Two respondents made no specific mention of the influence of Family Life Centre on their chosen approach to family therapy. The influence of studies however, is implied from their responses.

"... pretty much systems ... I enjoy the fact of boundaries and getting the different structures right ... so, I suppose systemic is the main approach for me".

"... um, I go from a systems perspective initially, just to gain an understanding of the history of the family and to get an understanding of what patterns are recurring ... what I tend to do with that knowledge is often not share it, just understand it ... and then I work generally in the here-and-now of what is happening ...".

Only one respondent specifically distinguished her chosen theoretical approach as subscribing to a postmodern paradigm.
"A postmodern feminist stance ..." with *"... art therapy as an intervention".*

In the literature review (Chapter 2:105), discussion reflects on how postmodern feminism has challenged family therapy to address issues of power, patriarchy and inequality (Kjos, 2002:161; Goldenberg & Goldenberg, 1996:320). The postmodern feminist view questions the dominant discourses of daily life, exploring how these are maintained and perpetuated in society (Hare-Mustin, 1994:21).

From the findings it is clear that all of the respondents follow a cybernetic epistemology, albeit that the distinction between first- and second-order paradigms is not necessarily delineated.

During the exploration of this theme, most of the respondents indicated a shift in their approach to family therapy as their experience in the field grows. These comments will be integrated into the theme below, which deals more specifically with changes in theoretical approach over time.

- **Perceptions regarding initial encounter with chosen approach/approaches:**

The issue of the initial encounter with a chosen approach is explored in Chapter 4 of the literature review. According to Spinelli and Marshall (2001:6), a theory may immediately feel 'right' for a therapist, or it may feel odd and uncomfortable. In

addition, aspects of the theory may be valued, while others are ignored. In order to understand how we 'embody' certain theories it is necessary to understand what they mean to us and how we put them into practice. These authors state further that who we are at the time of the encounter with a theory will influence how we respond to it at that time.

Two respondents felt an immediate liking and comfort with the initial encounter with their chosen approach. From the statements below, however, it is also clear that this liking and comfort do not necessarily remain static. Again, this issue will be dealt with in the theme below, dealing with changes in theoretical approach.

"I loved allowing the family to create their own narrative ... I loved listening to the family's story ... I loved more using the language of the family, and that we didn't bring in our own language ... so in the beginning I loved all that ... but that's what I started questioning".

"... I liked the structure of it and it gave me a framework to work from, so ... from a systems perspective I could actually gain a better understanding of what the subsystems, what the different collusions, what the different triangles were ... that's not to say that it works for every family ... it gave me something concrete to work from, and then branch out, so I don't work purely systems ... my approach is more eclectic but its given me a good framework ...".

From the above responses it is apparent that the initial encounter with the chosen approach was one of liking and a fit with the self of the therapist. However, changes in this perception are evident as experience was gained. Spinelli and Marshall (2001:169) believe that if an approach feels right for the therapist it is more likely to be practiced in a way that is authentic to her, thus benefiting the therapeutic process for the family.

Of the remaining respondents who felt less comfortable with their early encounter with the chosen theoretical approach, one respondent felt that her approach has *"... evolved*

from research with rape survivors and the failing of the modernist approach ... a challenge to the idea of having control ... and a challenge to imposing Western models in an African setting". This respondent felt the need to *"... search for something that makes more sense…".*

Although not specifically relating to family therapy theory, it can be speculated that for this respondent there was no initial feeling of theory making sense, that it was something that research highlighted as non-viable in a particular setting, thus resulting in the respondent having to search for a theory that had a better fit with her experience and with her authentic self. In addition, this respondent mentions the issue of culturally diverse practice, which according to Thompson and Rudolph (2000:349), requires consideration of the customs, norms, communication patterns and standards of behaviour of different cultural groups.

The remaining respondents expressed varying degrees of discomfort in encountering their chosen approach for the first time.

"Strange ... it took time to get used to it ... I did find it difficult at first, and that's another reason why I had to build onto it, using other approaches".

"I think as a student I was quite uncomfortable ... I didn't really have enough understanding of what it was about ... I didn't really understand that actually we all have different opinions and experiences and our own opinions ... I thought there was a right and a wrong and I was terrified of being wrong (laughs) ... I think as one gets used to it and takes the odd risk or two, in fact I'm very comfortable now ...".

As explored by Young *et al.* (1989:71) anxiety may be an inherent difficulty in training settings, as well as constraining beliefs about getting things right. These are factors which have the potential to impact on the acquisition of both cognitive and executive skills. From the statement above however, such feelings and experiences may, in time, be surmounted. The views of Berger (1995:311) (in Chapter 4:267), suggest that

personal competence and confidence develop over time and with experience, and that the development of an individual style lessens the need for the approval of others.

"I think every approach does feel strange ... I'm not a purist so ... I definitely do try things on for size and ... its very awkward initially, until I see what fits comfortably for me".

"I think initially I thought systems theory is fine, I've always agreed with it and thought it a very useful way of looking at things ... in terms of narrative work, initially I was ... I'd probably say a bit sceptical of it ... of course you take and discard some things, you decide that's not the way you want to go ...".

From these comments one can conclude that the initial encounter with a chosen approach did not provide the sense of "…coming home…" referred to by Spinelli and Marshall (2001:166). Of significance too, is the view that a degree of discomfort or dissonance may be growth enhancing (Spinelli & Marshall, 2001:169). Worden (1999:53) suggests that new family therapy practitioners lean towards a purist approach, typically the one they were exposed to in training, but that with experience there is often a shift towards eclecticism. The reflections above seem to corroborate this view.

The distinction between theory and practice for less experienced family therapists is evident from the statement below.
"When we studied it in theory, um ... I liked the theory, it kind of make sense, um, but we didn't have any practical experience as part of our studies so it was purely theoretical ... then when I came here as an intern and I had to do it! (Laughs) I think what I found was that it didn't make quite as much sense to me when I was doing it ... what I found was that it was maybe not an approach that I would necessarily take ...".

Once again, the influence of the organisation or supervisors within the organisation upon practitioners is evident from aspects of the statements already discussed, as well as those below.

"I was a little anxious about the narrative approach because it wasn't something I knew theoretically…".

During her early experiences of family therapy this respondent shared her feelings as follows.

"… I was aware of my own anxiety … of how I was coming across … so I was kind of observing myself being observed and yet trying to hear what the family were saying … so that threw me in the beginning …it absolutely threw me! Maybe because I was holding onto (supervisor's) *perspective too much".*

The researcher speculates that the level of counselling experience at the time of exposure to a theory may influence the response to it. As a beginning family therapist the number of theories may prove overwhelming and there may be a sense of security in following what is the norm at a particular organisation.

An area of shared experience with regard to the exploration of this theme reveals that all of the respondents, whether the initial encounter with an approach was comfortable or not, feel the need to build on that theoretical foundation. The statements below bear testament to this observation.

"As I started to let go of the student role, being observed, being evaluated, the performance anxiety started to ease … and that's when I started to bring in the psychodynamic … not in the purely psychodynamic way where you are analysing everything … it was more guiding my uh, thinking, for the next session".

"But I've gone more analytic … I've shifted … not that I think they can't be married and not that I don't subscribe to systemic work … I believe that there is so much depth psychodynamically … I think you have to have a deep understanding of that before you can work narratively or systemically".

According to Gladding (2002:119), Carr (2000:163) and Goldenberg and Goldenberg (1996:111), efforts to integrate systemic and psychoanalytic concepts resulted in object-relations theory, discussed in the literature review (Chapter 2:119).

"I don't think it should be the only, the dominant theory… (referring to narrative theory) *… maybe you've got to look at other stuff, maybe its eclectic …".*

In conclusion, many of the respondents initially struggled to make sense of family therapy theory, although a sense of personal embodiment of theory evolved or is in the process of evolving, over time.

- **The way the approach/approaches was/were chosen:**

According to Zeddies (1999:232), attachment to a particular theory, therapist or supervisor may prove limiting in that it becomes difficult to consider alternatives. Reflective thinking is essential if one is to consider how such allegiances impact on the therapeutic encounter. With regard to the way in which an approach was chosen by the respondents, the impact of academic training and the organisation where family therapy practice occurs is once again evident from the responses explored below. Aspects of this theme integrate with the section above, which focused on chosen theoretical approach.

"It was essentially part of my studies …".

"That was what we were taught to do … it was all I was exposed to and you know, when you're studying you don't have time to go and find out more stuff …".

"I think RAU is more systems based although they like to expose us to all aspects or different theoretical approaches…".

" I think it depends on where you were trained … at Wits there's a big systems approach … you don't get a lot of input on psychodynamic theory … you get some on humanism

but you don't get much else, so what you learn is usually what you practice unless you are very invested in seeking out other knowledge …".

As previously explored, Keith (1987:61) suggests that the self of the therapist may become obscured by theory and training, thus inhibiting spontaneous behaviour and thought, and also in the opinion of the researcher, a search for an approach that may be experienced as more authentic to the self.

"It was chosen for me (at Family Life Centre) *…".*

Other respondents have engaged in a more personal journey of exploration to find their chosen approach.
" … I don't think I chose it … I just think it became part of my … my thinking about people and about relationships and about the family …".

For one of the respondents, her chosen approach arose from a need to understand family, mental health, and the larger community in a context that was more relevant to South Africa than the normative Western model of family life. This opinion highlights the view of Comb (in Merry, 2002:55) who states that the development of a theory that is personally meaningful is a highly idiosyncratic and creative process.

Two respondents specifically mentioned how their personal therapy experience has influenced the way in which they chose their approach.

"Maybe my own therapy … and my own inclination to what I felt I needed for myself (as a client) *…".*

"My own … I had therapy for myself … and I think I picked up quite a few of my therapist's way of doing things …".

Thus it can be concluded that training institutions and practice organisations, and to some extent the personal experience of therapy, impact strongly on the way in which a theoretical approach is chosen and implemented. The personal embodiment of theory occurs perhaps, with enhanced personal and professional experience and development.

- **Influence of chosen theoretical approach on personal values/beliefs:**
- **Influence of personal values/beliefs on chosen theoretical approach:**

The themes relating to theoretical approach and personal values and beliefs are combined as most of the respondents spontaneously entwined these aspects, making separation arbitrary and unnecessary.

In the literature review (Chapter 4:226), Spinelli and Marshall (2001:1) state that very little attention is paid to the relationship of the therapist with the chosen theoretical approach. The choice of approach gives a sense of meaning and purpose to therapeutic practice. The findings reveal a fascinating mixture of responses, perhaps reflecting the individuality of personal values and perception of theory. Van Dyk (1997:99) states that values play an important role in the social work profession and underlie the mission and aims of social work. Both personal and professional values are significant, with the former influencing interaction and the latter reflecting the way one practices.

For one respondent the theoretical approaches used and values both did **and** did not fit, as her comments illustrate. Referring to the narrative approach, the values of the respondent are reflected as follows.

"I believe in equal power, um I believe in multiple realities ... I don't believe in a core truth, I don't believe in a core reality, I don't believe in causality, that A causes B ... I think there are multiple factors and variables ... my values are of equality, client self-determination, all of that kind of stuff".

This respondent feels that while there is congruency between her personal values and narrative values, a dilemma has arisen, as she explains.

"However! Because I've shifted more to object relations ... psychodynamic theory, um that doesn't fit 100% with my values ... because I'm the expert in the room ... there's a

whole different power, and I'm not too comfortable with that ... its definitely a hierarchical space, even amongst the therapists and the trainers, and definitely you get your elitist therapists ... and I'm not comfortable with that, but I do find it a very valuable therapy, although it doesn't fit with my values".

Thus one can assume a certain clash of values relating to psychodynamic theory and the personal value of equality and shared power. Whether and how this impacts on the therapeutic encounter with a family is perhaps part of the personal journey of this particular respondent.

The issue of a degree of clashing of values was explored by another respondent, not so much in terms of the approach used, but more related to the way in which the reflecting team operates. While this theme is dealt with more specifically later in the chapter, the issue for this respondent is sensitivity towards the sense of intrusiveness families may experience in response to the one-way mirror, the camera and so on. In addition, for this respondent there are times when differences in interpretation by team members give rise, on occasion, to a sense of personal discomfort and feeling different. So while her values and approach fit comfortably for her own practice, aspects of reflecting team work raise concerns.

Another respondent feels the need to actively engage in a personal journey of discovery.

"... A search for a model that is congruent with my beliefs and values ... its fine studying theory for the sake of theory but working with people I was confronted with finding a model that worked for me ... the litmus test of a theoretical approach is whether I feel comfortable with it, whether it fits with my beliefs and values, and whether it's therapeutically useful to clients ... that's what I was searching for!".

For this respondent her preference for art therapy, at times eclipsing the traditional verbal approaches, is an aspect that evolved from the moulding of an authentic model for practice that was the result of the expressed needs of clients.

For the remainder of the respondents there appears to be a sense of congruency, perhaps the difference being one of degree, regarding the influence of theoretical approach and

personal values. The value of being non-judgemental and respectful was mentioned by several respondents, and some respondents also explored the impact of studying on theoretical approach and personal values. The comments below illustrate.

" ... they definitely influence, um, hugely ... as a therapist whatever approach I take its got to be me, its got to be an extension of me ... its got to have a personal aspect ... obviously we can extend our perspectives while we study and train, because we enlarge our repertoire ... I have more compassion for the family after studying, where before I was slightly more judgemental ... I think I'm a better therapist through the studies".

"I think with extra studying I got an idea of other options ... this whole thing of us all having different experiences, each person in the room having a different experience of the family, so you have multiple perspectives, that sort of fits for me ... systems is how I think ... I think it comes from my earlier training in zoology, and seeing the world in terms of wholeness ... it fits with the whole systems theory, um, I think its not in opposition at all".

"I think my, um theoretical approach is more based on a value system as opposed to a theory ... I would say the most important part of doing this work is to ... to not be judgemental, to not have a corrective approach to working with people ... creating a context for change, for exploring the possibility of change in a direction that makes sense for them, so its very much a second-order understanding ... so I hold to that value ...".
For the respondent, there arises too, the issue of being in tune to the needs of the family, thus at times she will take a more directive, goal-oriented role, remaining focused however, on empowerment and the development of insight as a primary concern.

"Personally I like to have an understanding of where things come from and where they are going to ... and for me that gives comfort knowing, um, that things don't happen in isolation, there's no randomness about behaviour, that there's a structure that has developed and created and sustained a particular behaviour for whatever the family needs it for ...".

Hence for this respondent there is a sense of congruence between the systemic approach and her own need for structure and a measure of predictability.

"They are so intertwined, um, I can't really untangle the two ... my personal approach and my theoretical approach are both part of me ...".

It can be concluded that personal values and theoretical approach are strongly linked in the perceptions of the respondents. The importance of knowing one's values, having theoretical knowledge, knowing which theoretical aspects fit with the self, clearly impact on the choice of approach. However, as explored earlier, choice of theoretical approach is also affected by academic training and the approach favoured in the organisation. This does not imply though, that personal values are less significant.

- **Impact of chosen theoretical approach on personal/professional life:**

This theme seemed to be thought provoking for most of the respondents, requiring time to capture and verbalise their thoughts. The range of variation in responses reflects the individuality of perception with regard to the interpretation of the theme, and the meanings evoked.

One respondent, after some thought, believes the following.

"... Maybe it works the other way round, um, in that the value comes from me so it doesn't impact me, it maybe ... um ... possibly it allows people to feel comfortable, to not feel 'sick' ... to feel safe to explore ... and yes, it feeds me because you know, I feel empowered to continue with that framework ... ".

This respondent believes that her values impact her professional life in that through helping others, she is enriching her own life, but with some qualification.

" ... its for me, its what I'm doing for myself ... there's just so much I don't know and the more I get into it the more I'm aware of what I don't know ... and if I ever start to believe that I can do this and that I hold the key, then I know I need to get out ...".

Another respondent believes her current position to be in a process of transition.

"Well … let me think … the impact of my theoretical approach … which is depth work … on my personal and professional life has forced me to a deeper therapy …".

The conflict for this respondent has resulted in a return to her own therapy in an effort to find a more comfortable space. Confusion came about in not being able to put into practice the techniques of narrative therapy, despite a feeling of real comfortableness with the philosophy behind it. In addition, in seeing the value of deeper work with clients, there are difficulties in this approach that affect this respondent, as her comments imply.

"… I think what's difficult for me is that where I'm at, at the moment does pathologise, so I have to be careful at not pathologising … its very uncomfortable at the moment …".

The struggle for this respondent is her real belief in the necessity of working on a deeper level with families.

"… when you don't work deep enough or understand in a deep enough way, our clients leave with inauthenticity, a wooden aspect of themselves as opposed to something that is really integrated in a really authentic shift …".

In some ways this respondent sees a lack in her personal growth, that her own work has not yet been on this deep level and hence, her choice to struggle to find an authentic fit.

One respondent feels the impact of theory on the personal and professional self relates to viewing clients within a context or framework that is relevant at a certain time, and that the approach may differ from time to time.

Another respondent believes that the approach used impacts positively on her own sense of anxiety.

" … I think giving structure … unpredictability makes me anxious and because I'm a highly anxious person to start off with, I need to know that some things are … there's space for some control, and that there is some predictability in some things … so I think from a professional point of view it gives me something grounded that I can work with, that I can hold on to…".

Other respondents view their theoretical training as providing a platform from which to work, that impacts on how they practice, but which feels 'right' in terms of their personal beliefs.

"I think ... you know I was trained person-centred only and um, I think it's given a breadth to the way I work with individuals as well ... how they fit into the system and how the environment reflects on them ... that gives a ... a more ***whole*** *picture of their lives".*

"...it's not like I have to go in and put on the person-centred approach while I'm in the therapy session, its part of my personality".

" ... I think it does impact your personal life um, professionally obviously because that's what you are choosing to do ... that sharpens how you work ... but personally you do apply those aspects into your personal life, in your own marriage, into your friendships, into your parenting style ... but I think personally, your own values and belief system is a stronger pull ... but there's definitely a cross-pollination between the two, and obviously your experiences in the home will influence how you are professionally as well".

In conclusion, the impact of the chosen theoretical approach on the personal and professional self is felt to impact to a differing degree by the respondents. Some experience the impact strongly, others less so.

- **Philosophy of chosen theoretical approach and fit with personal/professional preferences:**

Gilbert *et al.* (1989:10) believe that theoretical orientation reflects personal constructs and perspectives on life, that is, one's philosophy. Understanding one's paradigm is essential and according to Pocock (in Rivett & Street, 2003:49), without such an understanding there is a risk of being overly rigid or theoretically capricious, without consideration of the relevance to the client family. However Spinelli and Marshall (2001:169) suggest that a perfect fit is not a necessity and that a degree of dissonance may be growth-enhancing. Some of the respondents experience a comfortable fit

between the philosophy of their approach and the fit with personal and professional preferences. Others however, are still in the process of journeying towards finding this fit, or finding an alternative fit, as the comments below suggest.

The theme of a journey towards a fit is evident to a degree in the responses below.

"... ja ... I would say it's a comfortable fit and it relates to my philosophy but that's also because I've practiced in that way for a long time ...".

"... if I was more at a distance from them (clients)*, if I relied more on a psychodynamic approach where self is always hidden it wouldn't be as expensive in terms of energy and time and personal resources ... but I don't think I would be as effective as a therapist so it's a bargain I've chosen to make".*

"... I think I've chosen very broad approaches, they are not very specific, they are not very defining of how you behave which I like ... I have a problem with being too boxed in (laughs) ... they might be too broad and not specific enough but then I borrow pieces from other, um, insights to fill in a more detailed understanding ... its not a perfect fit, put it that way".

"Ok, well let me reiterate ... I think that the human being, psychodynamically, spiritually, intellectually, is so complex! ... If we stop journeying or we take one theoretical approach and we put that as a fundamental approach I think we're losing out and that's why I'm exploring different things ... as a professional I'm obliged to explore the depth and complexity, (of the human condition) *no matter where it takes me".*

For one respondent the philosophy of her chosen approach, namely empathy, non-judgement and unconditional positive regard, fit with her value preferences, however she feels at times the need for more directive intervention, to move the process forward at a faster pace. Another respondent states that her training was non-directive in nature and while she believes in the value of this approach, her personal inclinations may challenge

her at times. It would seem that the journey towards a fit is ongoing for some of the respondents, and that philosophy and methodology are at times in conflict.

"I sometimes find it quite difficult to … I find it difficult not to give people advice, what I think would be the best way to go, um, and I have to restrain myself".

One respondent related this theme to her experience as an intern, where she felt *"... you come in as the underdog …"* and that this frame impacts on how you view or practice an approach because of the element of evaluation by a supervisor. Although the philosophy of the approach, that is helping families in difficulty, fits with the respondent, the actual methodology of practice of the reflecting team is a less comfortable fit.

"I would prefer to have the family and the team in the room together, thrashing it out … the window thing didn't sit right with me … and I think you have to be very careful of how you choose your team, um, its important that the team gel … and you also have to be careful of power imbalances in the team … ideally that should not be there …".

Her feeling is that should she use family therapy as an intervention in private practice in the future, she would do things very differently in order for the approach to fit with her values.

Respondents who seem more certain regarding the fit between theoretical philosophy and preferences shared the following reflections.

One respondent feels that the philosophy of her approach, which is about trying to understand how meanings are constructed and deconstructing meanings, *"... strips away the assumptions of societal varnish of what people tell you … the plurality of stories, no one explanation, that is close to my heart …".*

Exploring further, her preference for art therapy may create a difficulty for some clients, however she believes *"... it's who I am, I'm an artist, it just comes through so it's hard for me not to have that part in the room when I do therapy … sometimes they don't want to make art, maybe they've had a bad experience with making art … and that can lead to tension … but then I work verbally …".*

"I think, the philosophy about it for me is that, um, by anchoring me in a structure gives ... more security than feeling that everything happens at random, and that there's no containment and that there are not boundaries that can be set in place ... so from a philosophical point of view having the boundaries of holding, for me, gives a family more security and a sense of mastery in specific areas ... and helps them contain some of the stuff...".

Of importance for the respondent above is the degree of fit between the approach and her own anxiety which she feels, is allayed by having a structure from which to work.

"I think there's a great fit ... there's such an overlap between who I believe myself to be, where I've come from, how I've evolved as a therapist, that's led to me studying further ... so its kind of like the heart thing with the head thing ... as you become more in tune with who you are at a deep level its led me to want to learn more and grow more and evolve as a therapist ... I can't separate the person from the therapist, you are the tool in the work ... so the philosophy is again the value system that I mentioned ...".

This respondent believes that the personal journeys of therapists and clients converge at times, which is about the reaching of potentials and growth. According to Satir (1987:19), techniques and approaches are tools with different results when used by different therapists, suggesting the impact of the self upon the client family occurs regardless of and in addition to, the espoused approach. Spinelli and Marshall (2001:169) believe that the experience of an authentic fit regarding approach is more likely to be practiced in a way that benefits the therapeutic encounter.

The journey towards finding an authentic fit with regard to self and theory is a challenge which may prove to be ongoing. Perhaps there are times in the career of the family therapist when the fit is more or less comfortable, with the latter compelling the journey to take other directions. The theme that follows may elucidate.

- **Changes in approach to family therapy:**

The issue of a changing paradigm is explored by Sexton (1997:11-12) and discussed in the literature review. Sexton suggests that a shift requires contemplation of theories on human behaviour, which may challenge beliefs and values and involve feelings of resistance and struggle. Clarke (2002:1) explored a personal epistemological shift that has the potential to be experienced as "… liberating or shattering".

All of the respondents feel that their approach to family therapy has changed in some way over time, with perhaps one exception where one respondent feels as follows.
"It's really such a new arena for me …".

For the majority of the other respondents their approach to family therapy very much relates to their personal journey into this field of intervention, as the reflections below illustrate.

"Oh, I think it changes all the time … we're influenced by the people, um, in the team … by what you are observing in other therapists, by different approaches to a case … I think that's the joy of being in a peer group, you're not limited by yourself (laughs) … so there's definitely change, and it's a good change".

"There was a radical change in that in the beginning, I was so aware of my own anxiety … I had no experience of family therapy … as soon as I was given a space to breathe a bit, um, I sort of calmed down and didn't need to be directive …".
For this respondent change was reflected in a shift from the need to be more directive in intervention, as a result of inexperience and anxiety, to a more relaxed way of being that allows for an enhanced therapeutic relationship with the family.

"I think it has changed … to be more encompassing … starting to look at bringing in more things … I think each of these theories is one way of looking at people and people are very complex … the more ways you can look at them and the more bases from which

you can stand and look, the better your understanding of them is going to be ... so I would say that I've moved to a more eclectic approach".

"Before I did family therapy I thought it was more of a quantifiable process, something that had a beginning, middle and end, one could see the process and have an expectation of what that would look like ...".

With experience, this respondent feels that her perception of the process has shifted, at times leading to a sense of frustration, but at the same time eliciting humility in practice and an ability to be comfortable with not knowing.

"... in sessions anything can happen, the dynamics can be anything, the changes can be anything, you don't know the end of the story, you see a snapshot of the process ... change probably manifests down the line ... ".

"So, initially it would be ... the way it's done at Family Life Centre ... which would be reflecting in the language of the family and I think that that's all beautiful but ...".

This respondent went on to elaborate on changes she would like to see in the theoretical aspect of practice at Family Life Centre.

"... I would want the team to have greater discussion on what is happening, exploring from multiple languages, which is narrative ... and really exploring in depth and then really talking in depth afterwards ... I don't think that's done enough, personally!".

For one respondent, her previous experience of family therapy was in a different organisation where a systems perspective was not used, thus for her the approach used at Family Life Centre is a change.

"... this is a better fit for me ... so I think because I've grown professionally I see the benefit of using a model that has more structure".

"I'd probably say its shifted ... I think inevitably you deepen your knowledge and you probably change the way you work ... I think probably in the beginning I was quite structured (structural family therapy) *... maybe to provide a frame that is secure if you're*

not an experienced therapist … as you feel more confident in your own ability you'll be OK to move away from that approach".

Of interest, the last two statements of two of the respondents reflect a difference relating to change and experience in family therapy. The latter believes herself to have become less structured with more experience, while the former feels that as she has gained in experience, she sees the benefit of more structure.

The views of Sexton (1997:11-12) touched on above, as well as those of Hanford (2004:105) suggest that the process of shifting one's approach may result in the experience of confusion and a lack of confidence in practice. It would appear however, that this is not the case in terms of most of this sample of family therapy practitioners. While change has taken place, it seems to be experienced as positive and growth-enhancing. However, for one respondent, the approach favoured at Family Life Centre has caused her to challenge her thinking with regard to the issue of depth in working with families.

- **Theoretical approaches that do not fit with personal/professional preferences:**

The choice of theoretical approach that does not fit with the preferences of the respondents shows variation, but also some similarities, as the comments below illustrate. The respondents were all very quick to respond with their reflections to this theme, and seemed certain of their opinions and perspectives. Of interest to the researcher is that many of the respondents laughed when reflecting on this theme, and curiosity around what evoked the laughter arises. Perhaps it feels easier to contemplate approaches that do not fit, or could it be that one feels more certain of what one doesn't like?

"(Laughs) … I would say behavioural therapy, although I use it with my kids! … I found existentialism fascinating for a long period of time but didn't find it that much use in the end … so, those two are probably the least close to me"

"I'm really not a behaviourist (laughs) ... really not! I think that there's a place for cognitive-behavioural work and I think without realising it most of us work in a cognitive way ... we work with core beliefs, changing core beliefs, thinking patterns, all of that stuff ... but its too wooden, I can't work in a behavioural way, but there is place for it ...".

"For me a directive approach wouldn't fit ... um, too much emphasis on structuralist, and too much emphasis on any approach ...".

"Well, um ... I think maybe the structural ... you know, if you think of Minuchin and the whole structural thing, it fits to a certain extent but I think that this whole thing of moving people towards normality which is in the mind of the therapist is not always helpful ... I would tend to see myself as more postmodern ... there are a thousand billion different families and what is normal? ...So anything prescriptive ... wouldn't fit with me".

"I've never felt really comfortable with an approach that is totally psychodynamic, I struggle to get my head around that, and I think with a family it would be even more difficult for me to use (laughs) ... so that would not work for me".

One respondent suggests a degree of pressure in work with families at Family Life Centre, in that there is always a long waiting list and to continue therapy with a family for some time denies other people the opportunity.

" ... so when you're feeling that way, working in a psychodynamic frame is quite luxurious, it assumes you have a long time to explore ... but I think for me working in that way doesn't fit because you focus on one individual ...".

"I don't know if you can be purely psychodynamic and do family therapy, it wouldn't work, and um, cognitive-behavioural, you know any purely first-order therapist that has this structured way of working ... although it's very comfortable if you're inexperienced to sit with say, the structural model, where you can set goals and give direction ...".

This respondent went on to explore her belief that approaches focusing on an 'identified patient' while disregarding a systemic view of the entire family would not fit well for her.

In addition, this respondent believes it is important to be sensitive to the needs of the family when contemplating an approach to be used, for example to consider the cost for families who perhaps cannot afford long-term intervention.

"I'm not psychoanalytical … I do to an extent, um, go into the history and past childhood experiences but I don't like sitting with an adult problem and spending all our counselling time on the under 6 years… its too limiting … I find brief therapy very frustrating, I feel it works superficially and I hate terminating when I see loose ends … and there's limitations to anything that is too individualistic …".
As with the respondent above, this practitioner believes in the importance of a systemic context in intervention with a family who have come for therapy.

The issue of the significance of the past is an important consideration which the respondents differed on in their views. As mentioned above, the respondent feels that dwelling on childhood/historical issues may be overdone. From an alternative perspective, another respondent explores as follows.
"I think pure social constructionist … because I feel that it doesn't take cognisance of the past and from a psychodynamic point of view, the past has enormous relevance to what is in the present, so I think using a purely social constructionist, um … I would struggle with that …".

Criticism of the cognitive-behavioural approach to family therapy is based on it being less systemically-oriented than many other approaches, with learning focused on an individual or subsystem within the family. Family dynamics are less significant a consideration and a therapeutic alliance is not emphasised (Gladding, 2002:189). Held (1995:1-2) questions the theoretical and applied implications of postmodern theories such as social constructionism, believing there to be a lack of critical scrutiny and evaluation. According to Gladding (2002:209), structural family therapy is criticised for inadequately addressing the complexity of family life, reinforcing gender-based executive and expressive roles and ignoring historical family issues. Criticism of psychodynamically-

based approaches focuses on linear causality, cost in terms of time and financial outlay, and intellectual capacity of the participants.

From the above one can conclude that cognitive-behavioural and psychodynamic approaches seem to be the least popular approaches in terms of fit with personal and professional preferences. However, as seen in the explorations above of other aspects of theory, the psychodynamic approach is viewed by a few respondents as extremely valuable in family therapy. Other less popular choices are structural family therapy, existentialism and social constructionism.

- **The way you would have been personally/professionally without encountering your chosen theoretical approach:**

The hypothetical nature of this theme posed a difficulty for some of the respondents, suggesting a perplexity in contemplating how things might have been without the experiences they have had and continue to have, and a task of having to take a close and perhaps uncomfortable look at such experiences. According to Grobler (2005), theoretical knowledge is insufficient without knowledge of "… how we know what we know". Thus practitioners need to know the paradigm that informs their thinking, even implicitly, and which contributes to the capacity for reflexivity. The researcher suggests that contemplation of how we might have been without encountering the chosen theoretical approach may give valuable clues as to dominant discourses or personal preferences that may impact on our thinking, and which have the potential to influence the therapeutic encounter.

"I can't imagine, um … I would have been more directive, more inclined to give advice, to be less empathic and not listen adequately … I suppose …".

"… I probably would have remained quite a structured person because I think I can be very structured … um …".

"That's a hard question! ... how can I say how it would have been if it hadn't happened ... you know when I was studying honours at Unisa, family therapy was a very important part of the module, I just gelled like this (clicks fingers) *at Minuchin's model because it gave me something concrete and so maybe I would be more locked into that…".*

With exposure to postmodern views, as well as psychodynamic thinking this respondent believes her journey to be ongoing.

"... I have a feeling that as my, um, as I continue to do the work it will evolve into something other ...".

"I think ... I would have gone more with my gut which I do work with anyway, but without the structure and I don't know how containing I would have been ...".

Earlier experiences of working with grieving families without the knowledge and structure of family therapy theory impacted on this respondents own anxiety, as her comments imply.

"...I didn't have a model and we just felt like everybody had this huge pain that nobody could hold, so I think ... I probably wouldn't have been as effective as I feel I am now".

"(Laughs) ... its difficult to know ...".

This respondent believes that without her additional studies, undertaken simultaneously with family therapy practice, she may have been more inclined to just go along with whatever the reflecting team were practicing. Further study however, has broadened her theoretical knowledge and facilitated a depth in understanding that which is authentic for her.

"Gee…".

After some thought the respondent went on to elaborate, believing that she would probably be more structural in orientation, with the expectation of a predictable pattern to family therapy.

A few of the respondents seemed more definite in their response, as the following suggests.

"I think I would have been too individualised, so what the systemic view has given me is a way of knitting together the family and holding the family …".

"I would have done it the way I see myself doing it in the future, either on my own … I don't necessarily feel the need for a team…".
For this respondent it seems that the family therapy as practiced at Family Life Centre is a less comfortable fit, and that her former inclinations are more authentic for her, and will possibly guide her future practice. The positive outcome of the reflecting team experience is finding out for oneself what is authentic and congruent to the self.

Another respondent believes she has remained fairly consistent in her way of functioning, and that the theoretical fit was, and is congruent with her self.
"I would have functioned in that way anyway, because the approach mirrors a lot of what I feel …".

The impact of early training, with its focus on more individualistic rather than systemic thinking is evident in the responses. In addition, the initial adherence to a particular paradigm seems to shift over time and with experience, suggesting that the respondents are on their own journey of discovery towards an authentically meaningful way of being in family therapy practice. For a few respondents, the initial encounter with an approach feels authentic and thus change is unnecessary at this juncture.

- **Further comments:**

Some respondents elaborated on their views regarding theoretical orientation, the variation of responses indicating the individuality of meaning the respondents give to theory.

One respondent emphasised the importance of the fit between the therapist's personality and philosophy, believing that authenticity, or the lack thereof, impacts on the effectiveness of the therapy with the client family, and also that the search for such congruency may be ongoing.

"You can't ignore that self-search and say this is the best fit for me ... maybe there's more work to do to find what really is the best way of working for me".

Similarly, another respondent shared the following beliefs.
"I feel strongly that theory must reflect the persona as much as the person reflects the theory ... the approaches are there to serve the process ... I think they're supposed to aid and sharpen our skill, and I think its an ongoing process ... I don't know if my approach will be the same down the line ... it's a dynamic growth process and as I get more confident maybe I'll change my approach ... I don't think its cast in stone".

One respondent mentioned the importance of eclecticism, stressing working towards change as identified by the family and using *"... whatever works within the realms of psychology".*

The opinion of Avis (1990:154) resonates with that of the respondent above, that is: the practice of family therapy is best served by studying the principles of both modernism and postmodernism.

The importance of keeping abreast of developments in the field was emphasised by one respondent, who shared some observations from her own self-study of a move towards looking at object relations theory in a systemic way. This respondent believes that Freudian analysis is misunderstood in that people do not recognise that one is always working with the system, exploring how the person interacts with the objects *"... whether they be internal or external objects, fantasised objects or very real objects".*

The importance of theoretical knowledge is evident in the responses, although the self as integral to that knowledge is also emphasised.

5.4.2.2 Intervention

- **Consistency between intervention and chosen theoretical approach:**

Responses to an exploration of the consistency between intervention and theoretical approach showed some variation. Some respondents feel that there is a consistent fit, as the comments below indicate.

"I think there is consistency in terms of my intervention and the model ... I use the knowledge gained from them (the family) *as a framework of the system, understanding how the systems are working in the family…".*

"I think if it's not consistent with your theoretical approach, if it really doesn't fit for you ... goes against the grain, um ... are you going to give it? (the intervention) *... I also think one must learn to trust one's intuition, and uh, if it really feels, uh, not great, then don't do it".*

"I think it is ... I think it's to do with the second-order practice in terms of my role as a therapist, to ***not*** *be the therapist ...".*

An element of discomfort was expressed by this respondent however, in that in intervention with families with an expectation of direction and guidance, there may be some feeling of being stuck or uncontained. This view concurs with an opinion expressed by the researcher, which is that for some families, seeking professional help implies an expectation of a professional opinion and a solution, and possibly a sense of disappointment if this is not forthcoming.

Another respondent also feels a sense of discomfort at times, not in terms of consistency between intervention and theory, but more so in terms of congruency between the self and the practice of family therapy at the organisation under study.

"It's more what is going on inside me where the fit doesn't really happen ... I think it's a matter of personal choice, some people love that approach and I'm not knocking it, I'm just saying its not necessarily the way I would choose to work".

For the respondents who are less convinced of consistency, the following reflections illustrate their experiences.

"Um … I'm not sure, sometime I kind of feel like you go with your gut, you know, what the family brings … I think sometimes you don't necessarily decide I must intervene in this issue or make suggestions that are related to this approach …".

"… When I'm sitting with the family I don't necessarily work in a psychodynamic way, my intervention is more systemic, utilising circular questioning, um, thinking about the family systemically … so I don't think my working is psychodynamic but my thinking about the family and my reflecting is more psychodynamic…".

Thus for this respondent the actual intervention with the family is not really consistent with the favoured approach, although if one considers an eclectic 'marriage' of the two approaches, then perhaps it is.

Circular questions are used in a number of family therapeutic approaches, including constructivist family therapy, the Milan school and social constructionism (Gladding, 2002:230; Carr, 2000:124; 2000:127; 2000:129). Criticism of circular questioning centres on the possibility of it being perceived as controlling, distant and uninvolved.

The experience for another respondent is as follows.

"I'm not always conscious of the theory I must be honest … um, I'm very conscious of the client and I find I just flow with it … but my approach is not always, OK this is how the frame works, lets go from step A to step B …".

According to Gilbert *et al.* (1989:8), the more insecure the therapist the more inclined he/she will be to hide behind the use of technique, at times failing to listen and explore with the family, and hindering the development of a therapeutic alliance.

Consideration of the fit between therapist's approach and family is the concern for one respondent, requiring flexibility and humility in the process of therapy.

"If I go with my paradigm, it may not be acceptable to the family, they may not relate, not want to work in that way ... and that throws the ball back into my court to tailor it, to find a better fit ... then come back with something closer to their way of understanding…".

Pocock (in Rivett & Street, 2003:49) suggests that a particular model is to be favoured only if it is useful at a particular time, to the therapist and the family. Thus, the concept of integrating theories is proposed as a way of working with the complexity of families in distress. This emphasises the need of being aware not only of one's personal paradigm, but of a wider theoretical basis to enhance intervention with diverse client families. The question of being 'purist' in one's way of working arises – is this model acceptable in terms of issues such as effectiveness with a particular family, ethical in terms of duration, fit with the family's values and so on. These issues require exploration beyond the scope of this thesis but are nevertheless, important considerations.

Thus it may be concluded that the fit between intervention and theoretical approach is not necessarily an easy one, at times perhaps not really conscious, with intervention coming from an intuitive level of feeling right for the therapist with sensitivity to the needs of the client family. For some respondents however, the fit between theory and intervention is perceived as congruent.

- **Contribution of chosen theoretical approach to a positive therapeutic relationship:**

Baldwin and Satir (1987:153) emphasise that therapeutic techniques can never overshadow the self of the therapist, and that it is the therapeutic encounter that is potentially healing. From the perspective of the researcher, any theoretical approach used in family therapy would, of necessity, need to be congruent with the self of the therapist, but also to some extent fit with the expectations and needs of the client family. The way of being with the family is influenced by the chosen approach, but also by the role the therapist assumes, i.e. expert or non-expert, as the reflections below illustrate.

"I thinks that's a difficult one … how it works for me is, um, at opportune moments sharing knowledge of how patterns have occurred and how they've been entrenched, giving the insight to create a shift … but you know, some people don't like too much knowledge so with some members of the family it doesn't always fit, but … on the whole its given them an insight as to why the pattern is repeating itself and how to break it, and to have the knowledge that if they continue the pattern it becomes a choice … so I think that's how it helps the intervention process".

"…I think if you work in an eco-systemic way … there is a greater hope for change because when you're in a system, by virtue of shifting one way, your outcome will change…".

One respondent feels that her approach empowers the client family to *"… be connected to their own strengths, resources…"* and to facilitate the process of becoming 'unstuck' and hence more empowered.

"Total and utter acceptance of their point of view, their experiences and reality…".

"I have such deep respect for the complexity of what's going on inside a person, and I never want to take that for granted … so they become my teacher … for me that fosters a therapeutic alliance … it allows for openness as opposed to expertness".

"Well I think it's very non-judgemental, um, and allows for difference and me not being the expert…".

"They (the client family) *perceive straight away that, um, they are valued, their input is of value … I'm not coming in as an expert …".*
The issue of what clients expect was a consideration for this respondent however, in that they may want more expertise from the therapist, thus making the therapeutic relationship less comfortable for them.

In consideration of the issue of expertise, Anderson (1999:5-6) believes that there is space for therapist expertise that is not instructing or rescuing. Rather it is based on dialogue, collaboration and a stance of not-knowing, which does not imply an absence of opinions, views or knowledge. Instead it is being open to the experiences and meanings the client family have. Minuchin (1999:13) and Bertrando (2000:92) criticise the not-knowing position, believing it to be pretence on the part of the therapist. Thus from the researcher's perspective, pretence would render the therapeutic encounter inauthentic. However, not-knowing does not have to be a pretence – it may be knowing our own views, beliefs and so on, but not knowing those of the client family, and being open to learning about them.

The issue of sensitivity to the family's needs with regard to theoretical approach and intervention was mentioned by one of the respondents.
" ... not holding onto it at all costs, if it fits great but you need sensitivity to what the family needs rather than hanging onto my paradigm ...".

As mentioned above, Pocock (in Rivett & Street, 2003:49) suggests that a particular model and thus intervention, may or may not be appropriate to the family at a particular time, requiring the perceptiveness of the practitioner.

In conclusion, the respondents seem to feel that their chosen theoretical approach contributes positively to the therapeutic alliance. The non-expert role is favoured and respect for the client family's needs acknowledged.

- **Contribution of self to a positive therapeutic relationship:**

According to Hubble *et al.* (1999:14), the therapeutic relationship forms the core of the therapeutic encounter, while Tallman and Bohart (1999:102) see this relationship as a resource that facilitates client self-healing. The perceptions of the respondents regarding the contribution of the self in facilitating a positive therapeutic relationship with a client family show much similarity, as the comments below illuminate. Some respondents stressed the importance of aspects such as warmth and empathy, while others emphasised

being able to join and connect with the families. Asay and Lambert (1999:34) describe the basis of human relational skills as warmth, empathy, understanding and affirmation, and an absence of judgement, criticism and blame.

"You've got to form a connection somehow with everyone in the room, so its about acknowledging every one in the room, giving everyone a turn to speak and if they're not speaking, trying to figure out why ... try to draw them in some way ... so its about being aware of everyone in the room ...".

"I believe very much in the skill of joining".

"I spend a lot of time connecting with the family before getting into the problem area ... it gives them a chance to size me up ... family therapy can be scary for people, so, taking time to really connect as one human being to another ... and being transparent ...".

The work of Carl Whitaker (in Carr, 2000:137) stresses 'being with' the family to create a context within which new ways of being may be experienced, thus enhancing openness and opening up possibilities for change. Similarly, Hanna and Brown (1999:77) believe that the hallmark of effective family therapy lies in the ability of the therapist to develop positive relationships with diverse people who may be in conflict with one another.

"I hope ... because of my community work background, I've always felt like I'm as real as I could be ... obviously within the boundaries of the profession, that a lot about creating a positive relationship is about the client knowing you are a real person ... that your input is sincere ...".

"I think by being containing, non-judgemental and very open ...".

" ... from a psychodynamic perspective there's that initial holding ... which can contain...".

For one respondent, the importance of self in building a therapeutic alliance lies less in connecting with the family, and more in the following.

" ... its about reconnecting them to themselves, bringing them back to parts of themselves they've forgotten ... reminding them of their resilience's and resources ... looking for the treasures in each person and let them see the value and the worth of that".

This view resonates strongly with the solution-focused perspective (explored in Chapter 2:95), wherein the emphasis is on strengths, resources, meanings and positives (Lee, 2003:390; Carr, 2000:133; Mills & Sprenkle, 1995:371).

In addition to connecting, the importance of aspects such as realness, honesty and transparency were aspects that some respondents emphasised, as mentioned above and below.

"I think just by maintaining honesty, that has really been effective in relationships…".

The importance of communicating with honesty and congruency, reflecting intuitive ideas to the family, even if not always accurate, is believed to be important by this respondent, as her comments go on to illustrate.

" ... working with my gut, if I sense something in the room, I bring it out, um, I may not always be right and it may not be received well but its always food for thought ... often I do leap in faith ...".

Lantz (1993:33) explored the issue of the internal responses of the therapist to observed family patterns, suggesting that such reflections allow for involvement and meaning in the emotional life of the family, enabling the internal state of the therapist to become relevant in the therapeutic relationship, facilitating growth for both therapist and family.

From the above it can be concluded that the respondents place value on the therapeutic relationship and see the self as an important aspect of developing this alliance.

- **Ways of relating to client families found to be most helpful:**

The views of Buber (in Baldwin D, 1987:34-35) (explored in Chapter 4:201) describe the I-thou relationship, wherein therapist and client relate openly and totally, facilitating wholeness for both client and healer. Buber suggests that even the most authentic and genuine therapeutic relationship is unequal in terms of focus, and that to leave a client untouched by the therapist requires the offering of one's total being to the other. This view goes beyond the concept of unconditional positive regard, authenticity, availability and empathic understanding. The reflections of the respondents to this theme relate strongly to the previous one, and reveal similar aspects to those already mentioned, as well as some differences.

As with the theme above, aspects mentioned were the necessity of listening, trying to understand the family from their perspective, allowing for differences, taking time to connect and build a rapport with the family, acknowledging everyone in the session, being aware and self-aware.

A further aspect mentioned is *" ... role modelling respect and care, um I've found that to be more effective than telling people to be respectful ..."*.

In the literature review (Chapter 2:130), Virginia Satir (in Goldenberg & Goldenberg, 1996:157) mentions role modelling by the family therapist as a way of coaching the family in more effective ways of communicating, that have the potential to validate feelings, build self-worth and create possibilities for change.

Two respondents specifically mentioned the issue of pathologising in family therapy.
"I think, um, for me what really helps, what comes to mind is not pathologising ... I really do believe in an 'identified patient' and I do believe that an identified patient is a product of the family dynamics ... so in not pathologising and looking at everybody's role, although sometimes that's very hard for the family ... but I think what it does is allows me to go in quite humble, teach me what's happening here ...".

"The very non-judgemental, the gentle approach, the non-critical, not looking for pathology … but also, there's a danger in only wanting to focus on the positive and then they don't feel heard … ja, its not ***not*** *hearing their pain, not sitting with it, but at the same time having to give them hope …".*

For one respondent, the issue of the reflecting team has the potential to impact on the ways of relating to the client family.
".. its about just being aware of everything that's going on in the room and making sure that you are relating to everyone in the room, um, at the same time, trying to forget the team behind the glass, putting that out of your mind and staying in the room with the family …".

The awareness of a team of colleagues, as well as a supervisor, observing from behind the one-way mirror may be disempowering and create anxiety for family therapy trainees (Young *et al.,* 1989:72). Whether and how this impacts on the therapeutic relationship with the client family is a consideration beyond the scope of this thesis.

For one respondent the issue of clients expectations may at times impact on how the therapist relates to the family.
" … I think it differs with each family, you know, some people come in with an expectation about how a therapist is meant to be … how you are as a professional and how you conduct yourself and how you relate to them …".
The issue for this respondent is that at times the family's expectations may influence one's response to them, and thus impact on the ways of relating.

Thus despite some differences, it would seem that the respondents are aware of the impact of their way of being on the therapeutic relationship, endeavouring to create a safe space in which the family can explore.

- **Values and beliefs about change in intervention with families:**

According to Friedman *et al.* (1995:203), the therapeutic conversation facilitates listening to the client family's goals which can be acknowledged and respected, thus creating the possibility for change, rather than the therapist being focused on a specific outcome. If one considers the possible impact of one's beliefs about change on the therapeutic outcome, the thoughts of the respondents are significant. As stated earlier, Van Dyk (1997:99) suggests that professional values reflect the way in which we practice, while personal values determine how we interact with clients. Many of the respondents emphasised the difficulty or complexity of change for families, while others were more expectant of change, even small changes, and experience frustration on occasion if it is slow to occur.

"... change is incredibly hard ... I mean hard on an individual level and when you are dealing with a family, and it's a blended family and it's her kids, his kids, our kids, it's incredibly hard".

"It's really hard to change, to change families, patterns of behaviour because they're so entrenched and any change in one person, um, the rest try to push them back into where they were because that's comfortable for the family ... change is difficult, and when its too difficult ... they opt out ... I think that happens often".

"Its difficult to quantify change ... families are dynamic, they come into family therapy because of stuckness or rigidity or the inability to move forward ... I never know what's going to shift that stuckness, which is intriguing for me ...".

For this respondent the role of the therapist regarding the change process requires consideration.

"... I don't have a concept of 'therapist as bullfighter', you know, I don't think I can go in there and wave the cape and make a miraculous change, but I think I can help them find what change needs to be".

Similarly, another respondent raised the issue of client responsibility regarding change.

"It's their ... it's what it means to them, and very early on when they're feeling hopeless and helpless they look to you for what that is, and I try to avoid giving them that ... I bring the hope without giving them the formula ...".

"Whew! ... I think, for change to really be sustained the family needs to be seen, but I also very much believe in part systems, so I think for the change to be sustained, um, therapy needs to be longer term ... and then the part systems need to be seen as well, be it the individual, couple, siblings ...".

This respondent suggests that the insights gained from working with other parts of the family system can then be taken back into family therapy, thus enhancing the potential for change to be sustained.

"... I believe that families can change and I believe that when they seek help they're at a stage when they're ready for change, regardless of how small it may be ...".

Two respondents mentioned the issue of goals of change, albeit from a different angle, and the expectations of the family with regard to change.

"I think as a therapist its got to start with flexibility because change for one family is a lot different to change for others ... your goals of change have to be realistic, sometimes the change can be very small ... sometimes you explicitly contract to agree on, um, a realistic outcome...".

"I don't set parameters or goals of change, I give them the opportunity to do that and regardless of whether they reach it or not, whatever has happened they will never be the same again ... because they've had an experience that's different to what they've ever had before ...".

In conclusion, the meaning respondents give to change is idiosyncratic, relating to how they see the family and the way in which they prefer to work with the family. Expectations regarding responsibility for change are mentioned and are likely to be

related to the self as well as the chosen therapeutic approach, which links to the following theme.

- **The influence of personal beliefs about change upon intervention with families:**

All of the respondents acknowledge the influence of their personal beliefs regarding change upon intervention, however the actual beliefs show some variation. For a few respondents, there is a strong expectation of change for families engaging in the therapeutic process, as the following quotes suggest.

*"Oh, it definitely influences, because I get **frustrated** (laughs) and sometimes I'm overly confrontational in that scenario, where I confront and maybe a different approach might have been more beneficial ... because I want to get the ball moving faster, and almost forgetting that its taken 30 years to create that pattern or whatever, and its not going to take a few sessions to change ... its something I'm trying to work on".*

"Hopefully it comes across as a strong belief in their ability to change, which hopefully impacts on their efforts to change".

Other respondents seem to believe that change is a slower, more incremental process, as the statements below indicate.

"Well, I think I like to take things very slowly ... you know, things like strategic would freak me out a bit because it almost, um, its so shocking ... for me its more important to have a good relationship and work on the miniscule changes rather that shocking people into change which may not be sustained...".

"I think what it (belief) *does is puts no pressure ... I think that they then realise that I'm not expecting them to be different ... I keep re-checking with them, where they're at and where they want to go, so that my own stuff doesn't get caught in the loop ... and that I don't end up projecting what I think should be happening, onto them".*

Clearly, the above comment requires continual reflection on the self, personal views of change and client self-determination. According to Carr (2000:117), our beliefs about family behaviour, and our beliefs about theories and professional biases influence our ability to engage in a self-reflective process.

One respondent feels that her beliefs about change allow her to empathise more deeply with the family

"I think it helps me to have a lot of empathy, none of us cruise through change, its hard ... and the fact that you have a family sitting in the room tells you that they are definitely finding it hard, they are stuck, and um, sensitivity in helping them make the change and realising that you can't make the change for them ... they have to make the change".

The issue of who holds the power with regard to change was raised by one respondent. She feels that one's belief about change *"... influences the power relationships ... I don't go in with big boots and a large whip, and imply I'm going to create the change ... and I think some families are quite disappointed by that ... they come expecting a professional swirl of the cape (laughs) ... that may be frustrating for some families ... others do get on board with the idea that lasting change is only going to happen when it comes from them".*

As can be seen from the two comments above, there is a strong belief that change is the responsibility of the client family, rather than that of the family therapist. One respondent however, suggested that the family therapist may feel at times that she has not helped a particular family in facilitating the change process, which may be disheartening.

One respondent feels that while she may envisage an outcome for a family, there is a need to go at their pace.

"... maybe where they're at they can't do that just yet, so, then I go with them, it's their journey, they will deal with what they can deal with now ... let them bite off the chunks they can bite off, and be available, just opening the window that little bit, as much as they can handle...".

For this respondent, the advancement of one's own beliefs about change may prove discouraging for the client family, making them feel that change is too difficult to achieve. Working at their pace enables them to deal with change as and when they are able.

One respondent reiterated her belief that change requires both long-term intervention, on an individual level, as well as on a family systems level.

Values and beliefs about change and the potential impact of this on client families are issues about which the respondents had clear opinions. Some emphasise the necessity of client responsibility for change and working at their pace, while others feel perhaps that their own expectation of change may motivate the client family.

- **Messages intervention may send to the families:**

According to Carr (2000:522), certain criteria are suggested in selecting the appropriate interventions for particular types of families and family issues. Such interventions need to be compatible with the client family's readiness for change, as well as with their beliefs, values and culture. The responses reveal variation regarding the messages interventions may send to the family, as the reflections imply.

One respondent stressed the issue of intervention giving the client family the message that the problem is a family system matter, rather than a family with one problem member (i.e. the symptom bearer).

"Well, the message might be 'hold on, you all need to work here', as opposed to pointing a finger …".

This respondent feels that the systemically-orientated nature of the message could make some families angry, that often they want to believe that one member is the problem.

The aim of one respondent is as follows.

"… try and let them give their own messages, facilitate a process where they get their own messages rather than me giving messages …".

In addition, this respondent emphasises respect for the family and affording every member the opportunity to have their say.

The issue of the message being respectful, honouring the family's story and way of being was stressed by a number of respondents, as described below.

"... that their way is the right way for them ...".

"... respect for each story, um, for the validity of each person's story ...".
This respondent believes her intervention gives a message of *" ... challenging assumptions about paternalism ... which is sometimes hard for men to take ... and its hard for women to feel OK with their own power".*

According to Hare-Mustin (1994:21), dominant discourses produce and sustain power against marginalised sectors of society and are maintained and perpetuated by both men and women. Reimers and Treacher (1995:194) (in Chapter 2:106) present a number of guidelines which may help the family therapist to explore the dominant discourses that subjugate people's lives. In addition, according to Collier (1987:53), differences in gender socialisation necessitates a careful use of the self and consideration of the fact that women speak in a different voice.

Giving the family a message of possibilities and hope is important for two respondents.

" ... help them explore various ideas to make things different ... and that you are there to help them make a change ... so its kind of a support role, a helping role but also a way of exploring, showing them various options".

"I would hope it was a message of, that there's hope for change and that you can do things different ... that the family have left the process having learned something about themselves that they didn't know before ..." .

The importance of being aware of the self in any messages that intervention may give to the family was mentioned by one respondent.

Thus the messages family therapy practitioners aim to impart centre around respect, hope of change, client self-determination and support for the process, but also challenge of certain belief systems.

- **Changes in beliefs about families since entering the field of family intervention:**

According to Orange (in Zeddies, 1999:230), therapists need to be prepared to revise their ideas, opinions and viewpoints in response to new information. Awareness of personal biases and theoretical positions that inform one's perceptions of clients is essential. Zeddies (1999:231-232) states that holding onto a particular theory may shield a therapist from the exploration of difficult or painful personal issues, and could encourage the development of blindspots in therapeutic perception. This necessitates reflection on theoretical commitment and personal allegiances. As could be surmised, changes in beliefs about families since starting family therapy intervention are divided, with some respondents stating that their beliefs have altered, while others feel they have stayed the same.

" ... I don't think my beliefs about families have changed ... I think I've always held onto the ecosystemic meta-theory ... that there's a broader system of the family and other systems at work that are impinging on the family ... I haven't lost that ... no, it hasn't changed my perspective at all".

"I think maybe I'm just more aware ...".

For one respondent, her earlier experience in forensic practice gave her an awareness of the difficulties family life may generate.

"... its all about families in trouble, and in therapy its also about families in trouble, so um, it kind of just cemented what I believe, um, that families are not always the greatest place to be ...".

The prospect of hope for change was also an aspect mentioned by this respondent.
"... if you've got a family coming for family therapy they are saying something about the unit, about staying together or needing help moving apart, whatever it is ...".

Belief in the relevance of family therapy was emphasised by a respondent who had this to say.
"... if anything they've (beliefs) *become stronger because I've seen families change before my eyes and its given me an enormous amount of hope that, uh, this is the road to go ... family therapy is really where the family should be".*

"I don't think they've really changed ... families can be very damaging but with support they can heal ...".

Another respondent mentioned the issue of the family as a potentially destructive milieu, engendering a harsh realisation of the power of families.
" ... (pause)... how destructive they can be, you know I didn't realise, I think before, the power of destruction, the power of the family ... how destructive they can actually be ...".

Several respondents mentioned their belief in the uniqueness of families.

"... you become more aware of the differences, how people, um, how different they are, and different ways of coping with things and um, that there isn't one way ...".

"Ja, I think they have ... you come in with an idea of the way a family should be, and that idea is largely influenced by where we come from in our own families ... over time you encounter many different families and different kinds of relationships ...".

"I think its constantly changing, I think as you experience different problems, different client situations you perceive families and their needs differently ... as you look at each family your perspectives adapts to what you see in front of you ...".

As can be seen, the final two comments by respondents emphasise their views pertaining to a process of changing beliefs about families.

Thus for some respondents, family therapy practice has not significantly changed their views or beliefs with regard to families. For others however, a shifting perspective is evident in their response to the uniqueness of client families.

- **The ways the chosen theoretical approach may have challenged views, beliefs and attitudes regarding intervention with families:**

As explored in the literature review (Chapter4:223), Karter (2002:66) believes theory to be a crucial element in our understanding and implementation of therapeutic practice. It is however, an aspect rather than the primary force. Theory is a necessary foundation for the development of a therapeutic style but without self-awareness and reflexivity it may be an obstacle to family intervention. All of the respondents believe that their chosen theoretical approach has challenged their views and attitudes towards intervention with the client family, although the extent of the challenge varies.

For one respondent her own belief in **not** labelling an individual or symptom bearer in the family system, usually diagnosed by an outside source, may be hard on the family who may be invested in that label, particularly if it means that other family members feel they don't have to or want to look at their part in the system.
" ... I think I struggle when a family comes with a label on one of the members ... I find that very hard because then the family seem to get hooked into the label, and it can be a good escape for everybody ... to put everything on one person, whereas the problem is clearly a family issue ...".

One respondent believes that the theoretical approach she has been exposed to at university and at Family Life Centre has not really challenged her views regarding intervention. Practical experience has proved to be a challenge however, primarily with regard to clarifying that it is not the way in which she will work in the future, when she intends to enter private practice.

" ... it became clear to me that this was not how I was going to work ... it just wasn't comfortable".

Some respondents feel that one's theoretical approach does challenge intervention in that you realise that there is no one way of working that suits every client family.

"I suppose probably that you can't have one way of working and believe that its going to help everybody ... you have to be more ... realistic".

"Well I think, you know, before I started I thought much more that there was a right way, a wrong way, and that has changed quite dramatically (laughs) ... I think that's probably the most important shift".

As previously mentioned, Young *et al.* (1989:71) explore the issue of therapists who may have constraining beliefs about doing things 'right', and that this may impact on the acquisition of both cognitive and executive skills, while Biever and Gardner (1995:49) suggest that there is a tendency to either/or thinking, a search for the right idea. The reflecting process illuminates differences in meanings through the generation of dialogue. From the researcher's perspective, the valuing of multiple ideas may be experienced as liberating for the team members, lessening the need to be right and creating a context wherein many possibilities are respected.

"... you sometimes think you know how this is going to be solved, but just because it worked for one family there is no reason for it to work for any other family (laughs)".

"... there's always times where you find that reality doesn't fit the theory and I feel I'd like to be flexible enough to accommodate that, and go with your gut ... I suppose your gut is really your value system plus your learning plus all kinds of things together ...".

For one respondent theory has challenged her to develop as a therapist, as her comments imply.

" ... its allowed me to grow, its allowed me to learn more, to explore more ... its allowed me to consider broader understandings, so its challenged me to think and study and cognitively engage a bit more with other perspectives ...".

The issue of integrating approaches in family intervention was significant for one respondent, challenging her to integrate theories in a way that works for her.
"Well, I think the whole thing is how do you marry a more in-depth individualised psychology with a systemic approach ... how do you bring the stories together?".

From the findings it can be surmised that the chosen theoretical approach challenges the beliefs and views of the respondents with regard to intervention. What stands out is the sense that there is no particular theory that fits all families and problems, thus challenging the respondents to be flexible with regard to the appropriateness of intervention.

- **Importance of being aware of your chosen theoretical approach in intervention:**

Opinion on the importance of awareness of theoretical approach in family intervention shows variation. For some respondents, the awareness is more in the background, as the following comments illustrate.

"Its not something I do consciously at all ... I think because I work eclectically ... I think its become part of who I am so I don't think it's a conscious thing, its just that I'm an information gatherer, so I automatically do it through the process ...".

"Well I think you have to be aware, um, because it's the thing that keeps you accountable in how you actually will practice ... so one needs to always be thinking about (theory) *… I think you have to keep that at the back of your mind, I don't think its at the forefront ... its also important that it becomes part of who you are ...".*
The comments of the two respondents immediately above emphasise the importance of theory becoming part of the person of the therapist.

"Its always a good awareness because it makes you more professional ... you are always working on a therapeutic level ... I like to go back and revisit theory, in the same way I like to read up if I'm dealing with a different client scenario ... but definitely to constantly keep the theory in mind, definitely makes me a better therapist".
The role of theory with regard to professionalism and accountability to clients is mentioned by this respondent and the previous one.

"I think ... it depends ... as a family therapist you should probably always know what you are trying to do ... but I think you can't always be thinking 'am I conducting myself in a way that allows for narrative intervention, or am I following narrative theory' ...".
For this respondent, forcing the theory to fit the family is a limiting and potentially harmful process.

"One always needs to have a theory in your head, you are always interpreting and analysing in your head in terms of theories that you know, but I wouldn't like to become a therapist who works purely psychodynamically or whatever, because I think that can set in a lot of inflexibility ... it mustn't become the be all and end all ...".

"Very important ... but I also think it's not everything ... the approach is the basis, your intuition is important ...".

The importance of the fit between theory and self was emphasised by one respondent.
"Because I think the theoretical approach has to fit your own values and because I, with my values, hold a particular theoretical approach, I am the instrument ... I have to know how my world is going to affect the way I intervene ... I have to know who I am and what language I am speaking, otherwise I'd be completely lost".

For one respondent, it is essential to retain the postmodern emphasis on language as a collaborative system.

"Very ... absolutely! I think if I lost, um, the importance of the language in which the family ... you know ... it I started to have um, a kind of professional language and didn't use their language ... I might lose them".

Collaborative language systems is the work of Anderson and Goolishian, and is a social constructionist approach, where language is the medium through which the family's problems are discussed and dissolved using dialogic conversation to allow meaning to evolve (Anderson and Goolishian in Hoyt, 1985:5). Minuchin's (1993:13) critique of language systems suggests that privileging language is limiting in that emotions may be obscured or even silenced by language.

Thus it can be concluded that opinion varies with regard to the theme of awareness of chosen theoretical approach in intervention with client families.

- **Further comments:**

A few respondents added further comments to their discussion regarding intervention.

"... go with where the family is at and in a direction that is good for the family".

"... have good managerial skills, enable each family member to have their say and get their point across".

The comments reflect the importance the respondents place on skills in facilitating the family therapy process.

5.4.3 Perceptions, Opinions and Experiences Relating to Participation in a Reflecting Team

The perceptions, opinions and experiences of the respondents regarding their participation in a reflecting team are explored in the themes below.

- **Knowledge of reflecting team practice prior to participation:**

The use of teams in family therapy occurs in many schools of therapeutic intervention, although they are used in different ways. As far as the respondent is aware, Family Life Centre is the only organisation in Johannesburg subscribing to reflecting team practice as endorsed by Tom Andersen (described at length in Chapter 3). The respondents had either no knowledge of reflecting team practice prior to participation, or had a little theoretical knowledge gained during university training, as the comments below illustrate.

"None, none at all, I'd never heard of it!".

"Nil, quite frankly (laughs)".

"Purely theoretical".

"Very little, just touched on in studies".

"Basically theoretical ... in a very superficial way".

"We did it in class ... it fascinated me".

The knowledge of this respondent was based on the experiential undertakings of a university lecturer who regularly travelled to Europe to take part in workshops on family therapy.

For most of the respondents, the encounter with reflecting team practice at the Centre is their first introduction to this way of working with client families. Obviously, undergraduate and postgraduate studies cannot encompass every aspect of theoretical training, thus rendering the family therapy work done at Family Life Centre significant in terms of training, both theoretical and experiential.

- **Expectations of reflecting team practice prior to participation:**

Expectations of reflecting team practice prior to participation show some variation, with some respondents having few, if any, expectations, while others had differing levels of expectations.

"No expectations really, I went in with a completely clean slate".

"I can't honestly say that I had any expectations, um, I was keen to learn about it, keen to finally get to do some of it ... um, I was expecting that it would work!".

For one respondent, her expectation was that the team would have an initial unstructured discussion about the family. Tom Andersen favours the hermeneutic tradition (discussed in Chapter 3:161), which refers to understanding and interpretation of meanings in everyday human behaviour. In creating meaning, we limit what we see and hear, thus inviting prejudice or pre-understanding of a person or situation (Andersen, 1995:12). In the reflecting process, the hermeneutic circle, the contemplation of different ideas may change the original meaning, and therefore our basic assumptions. Thus prior hypothesising about a client family entering counselling, typical of the Milan approach, would not be part of the reflecting process as propounded by Andersen.

A few respondents mentioned their own anxiety and nervousness in being new members of a reflecting team.

"Well, first of all I was terrified of opening my mouth ... I was with two other students who were very vocal and who had much more exposure to different theories ... it made me feel inadequate, that they were the experts and that I wasn't".

In addition, this respondent had the initial expectation that the team leader would do all of the 'work' while she could take a back seat, going along with whatever the rest of the team were doing. It would seem that this expectation possibly related to her feelings of anxiety and being new to the field, as well as being theoretically unprepared.

Young *et al.* (1989:72) discuss potential disadvantages in the use of reflecting teams, specifically around the issue of collective responsibility. Question raised include: who is responsible for the therapeutic outcome, and who controls the process and content of the therapeutic encounter?

"Um, I have to say I was probably a bit anxious ... I suppose going into a reflecting team as a new individual and you don't know the people in your team, it can be a bit nerve-wracking ...".

For this respondent her interest in working with families motivated her to engage in family therapy practice, without knowing at the time that the reflecting team format was the method used at Family Life Centre.

"... I didn't even know about the reflecting team, so it was all very new".

The experience of role-playing a reflecting team while at university created some expectations of reflecting team practice for two respondents. Such role-play had an evaluative dimension which proved more intimidating for one of the respondents, than actual practice in real life with a real family, as the comments below suggest.

"We did a few role-plays at varsity ... it was actually more scary at university because I think we were with peers and the judgement is much higher ... whereas with a family, they see you as purely a new opinion, a new viewpoint ...".

Performance anxiety is an aspect that may occur in settings where the element of evaluation is present. In the experience of the researcher, there are also occasions when the client family may assess the family therapy practitioner, for instance in terms of age, marital status, experience. Perhaps however, this is experienced as less judging than assessment by peers and supervisors.

The other respondent experienced role-play and whole idea of family therapy as follows.

"... incredibly exciting ... I found myself wanting to do more of it".

This respondent went on to say however, that family therapy in practice was a different experience.

"I thought it would be more directive, more measurable … it turned out to be a lot more mysterious and complex than I thought it would be … more intangible".
The comments of the respondent reflect perhaps, the difference between a theoretical understanding and actual experience.

One respondent entered reflecting team practice with high expectations that became more realistic with experience, as the following statement testifies.
"I had very high expectations, I did! I thought is was going to be this miracle tool (laughs) … but it didn't quite work that way (laughs) … I didn't realise how ***careful*** *we had to be of what we said … you have to present it in a way that is comfortable to receive and its not confrontational …".*

According to Andersen (1995:15), learning to go slowly, seeing how clients respond before saying or doing the next thing, being sensitive to cues that something is too unusual for the family, are ideas that led to early reflecting team practice. The shift from and either/or frame to both/and allows for a sharing of many perspectives on the same issue (Andersen, 1987:427).

The expectations of one respondent were met in the reality that is reflecting team practice.
"I expected it to be … um, just that! To be almost like where the team becomes another therapist who's looking at another level of communication, of interaction … and to present that to the family … and I suppose, that is what happened".

As can be concluded, the expectations of the respondents, or lack thereof, impact on the early experience and perception of reflecting team practice.

- **Experience of being an observer of the client family:**

The experiences of respondents observing the client family shows much variation. Some respondents focused more on how they felt early in their experience of being in a reflecting team, specifically with regard to the issue of observing fellow family therapy

practitioners in action, although this focus shifted to the family over time. Perhaps this indicates the anxiety inherent in exposure for practitioners new to the field, and their need to observe fellow team members, and perhaps compare or evaluate their own level of competence.

"I think in the beginning it was very much a case of observing the therapist with the family ... there's such anxiety about your turn coming up ... and I think that's often what drives people to want to go into the reflecting team because actually you learn so much more from observing a session in progress ... I didn't realise that till now, that we are reflecting on it, that's what it is! And it wasn't just for me, I could see in the other students that being true as well ...".

This respondent was alluding to her earlier experiences as an intern, wherein she underwent a quarterly evaluation by the team facilitator. Carlson and Erickson (2001:202) state that a didactic, hierarchical approach to training values expertise above personal knowledge and experience, possibility giving rise to self-doubt and even a sense of incompetence. On the other hand, as can be deduced from the comments of the respondent above, the need to learn through observation may be very motivating, perhaps transcending the experience of anxiety.

The theme of evaluation resonated for one of the other respondents who started family therapy in her intern year.

"Initially I was probably more keenly aware of the kind of, power balance in the room ... so it was around being careful ... I never felt I could kind of cross what was being said, argue or disagree with it ..."

Although for this respondent there was space for a different voice in the team, there was a power dynamic in the team that tainted somewhat, her intern experience of family therapy practice, *"... it was subtle ... but it was there".*

The issue of power in training settings was discussed in Chapter 3 of the literature. According to Edwards and Keller (1995:142), a positivist position emphasises a hierarchical structure. These authors quote Michael White who states that such a position

emphasises learning 'correct' methods of intervention which may limit the opportunity for collaborative dialogue and thus a co-created concept of change that fits for the client family. While a hierarchical stance is not the intention of reflecting team practice at Family Life Centre, clearly for interns, and perhaps even for teams composed of colleagues, there is an element of evaluation and being 'taught' correct methods of intervening with the family by the more experienced team members. White (1990:77) suggests that disagreement on what is deemed correct intervention will be slanted in favour of the trainer or supervisor, and emphasises the importance of knowing the practices and ideas of a particular agency where training will be undertaken. On the other hand, Biever and Gardner (1995:50) state that a belief in the value of all ideas, regardless of the level of experience of the team member allows for fuller participation by all people in the process.

The opportunity for learning through observation was stressed by some respondents.

"Fascinating! ... you very seldom get the chance to actually observe another social worker interacting (with the family) *... so that's a lovely learning experience ...".*

"Um, I actually liked being an observer, um, because you almost can stand back and watch what's going on, and I think you get a different idea from when you're in the room ... so I liked being able to see it from a different place or space".

Lax (1995:161) believes that the role of modelling inherent in the reflecting process has received little attention. While in this context it refers to modelling for families by team members, the researcher is of the opinion, that modelling can be helpful to family therapy practitioners as well.

"As a therapist it gives you a valuable opportunity to see the relevance of particular ways of working ... I would say it's a valuable and positive process ... for the therapist in terms of a learning opportunity, but I think sometimes its not always valuable for families".

This respondent feels that family therapy with a reflecting team may be just too strange, too unusual for some families, thus limiting its usefulness. With regard to the issue of observing other practitioners, the researcher expressed the opinion that the opportunity to observe fellow team members is highly valued, and provides an enriching learning experience. The view of Reimers (1995:228) (discussed in Chapter 3:171), suggests that reflecting team practice is not only a different way of thinking but also a different way of relating to clients. While Reimers (1995:229) believes the approach to be both creative and "…refreshing…", for some families the reflecting team may be too 'different', perhaps even alarming, intimidating or "…plain crazy".

For other respondents, their experience of observing was more on the family, and less on the performance of the primary therapist in the room with the family. Some anxiety is however, obvious from the remarks.

"I think initially ... I used to focus on the people talking, but my awareness now has shifted to the people ***not*** *talking ... because that gives me an understanding of who listens to whom, who withdraws, or who carries, um, a lot of stuff ...".*

For this respondent there is also some frustration at not being able to always intuitively sense the atmosphere in the room, and feeling at a distance.

"... what I find difficult is that I work very much from my gut and not being in the actual room with the family, not being sure of what the actual emotion is ...".

This respondent went on to say.

" ...initially it felt ... it was a bit anxiety provoking ... I felt as if I was an interloper, almost invading a space that wasn't mine, almost like spying I suppose ... ".

This theme of being uncomfortable for the family was echoed by some of the other respondents.

"I felt voyeuristic, I felt almost uncomfortable for the family ... their discomfort of being under the camera and being on the other side of a team of people they've never met, um,

talking about their family problems ... it did diminish with time, although every time a new family comes in I seem to be acutely aware of their initial discomfort ...".

While families are well prepared (telephonically) for the format of family therapy with a reflecting team, it is possibly still something of a shock when they actually experience it for the first time – the process is unusual and if one considers that even with theoretical knowledge it still surprises family therapy practitioners, one can understand that for families the initial experience may be astonishing.

"Uncomfortable to begin with ... being a spectator and looking through a window into the family's kitchen ...".
Strean (in Karter, 2002:21) describes a certain "…voyeuristic pleasure…" derived from observing people who are "…emotionally naked…". Viljoen (2004:34) also mentions voyeurism as an unconscious motivation for the choice of profession, suggesting that there is a wish to view tabooed scenes without having to be involved in them. Within the context of the respondents' experience, while a voyeuristic aspect may be present, it is somewhat disconcerting, creating discomfort.

One respondent feels honoured to be able to observe a family in therapy.
"I felt very privileged to be able to sit and watch ...".

Thus the experience of being an observer of the client family ranges from feelings of anxiety regarding their 'turn', to one of awareness of power differences in the team and a resulting need to be 'careful'. Other experiences included feeling privileged to observe the family and other practitioners at work, and a sense of voyeurism that is perceived as uncomfortable to the respondents who experienced it.

- **Changes in experience of being an observer over time:**

Responses to the theme of changes in experience of being an observer revealed some differences. One respondent felt that her experience as an observer has not changed at

all, that enjoyment of the experience has remained constant. For others, the experience has become easier with time, as the following comments indicate.

"I feel less discomfort …".

"I became more confident …".

"As I became more involved, more comfortable with the team, with being a therapist myself, I think lost that (sense of discomfort) *…".*

The issue of a change in focus, from observing the family therapist to observing the family was again expressed by one of the respondents, who commented thus.
"I think over time it did progress to understanding what was happening within the family … and less about the students, less about the therapist … it became more about the purpose of why we were there!".

A change in the nature of observation was expressed by one respondent.
"I think I get sharper, to look for different things … initially I was so absorbed with what each one (family member) *was saying, I was less structurally observant … now I'll notice more of whose not speaking, body language … so I think you do get better at observing … you learn what to focus on because there's an overwhelming amount of information that comes out …".*

According to Hanford (2004:47), in reflecting team practice trainees learn through observation of the observations of others, thus becoming part of the observing system. The capacity for reflexivity challenges the ways in which the therapist thinks about the client family, as well as the self. Zimmerman and Dickerson (1996:115) suggest that the capacity for reflexive thinking allows for the contemplation of multiple possibilities in understanding experiences.

The value of observing as an opportunity to learn was expressed by one respondent.

"I felt very privileged to be able to be an observer and learn techniques as an observer ...".

However, for the respondent above, as well as others, there were also some negative aspects relating to change in the observer role over time, as the comments below describe. It would appear that the composition of the teams may affect the experience of being an observer.

"... but I used to get annoyed because the team used to speak all the time, about things that had nothing to do with the family! I feel so honoured to be working in this profession, that people let us into their lives, and then you sit behind (the mirror) *... and often make very judgemental comments about the people in the family ..."*.

Gergen (in Andersen, 1995:34) states that the language of pathology developed by professionals has become part of everyday life and contributes to a sense of limitation and loss of hope. Similarly, White (1991:142) states that professional disciplines have developed practices that determine the 'truth' and give an objective and unbiased account of reality and of human nature. Such a perspective reduces the possibility and relevance of other knowledge. According to Cohen *et al.* (1998:280), hierarchical systems may create a position of dominance and submission. Ways of minimising hierarchies include not talking about the family outside of their presence so as to maintain respect.

"I became frustrated ... watching my colleagues who seemed to lack the confidence and/or training to really hold the family, hold that safe space so that change could develop ... watching people who weren't effective in the role, seeing that it could become pointless".

According to Biever and Gardner (1995:49), the idea of multiple perspectives is easily understood on a cognitive level. However, there remains a tendency to either/or thinking and a search for the 'right' or 'best' idea. It can be presumed that an element of evaluation occurs on a number of levels, and not only by supervisors, as the comments above and below suggest.

"It changes over time, depending on the people you have in your team …".

For this respondent, the experience of being an observer changed in relation to the level of skill and practice experience of fellow team members – with a relatively inexperienced team, questions arise around the capacity of the team to intervene effectively to facilitate change.

In conclusion, it would seem that with experience, confidence and comfort increase, and the opportunity to learn from colleagues is valued. For some respondents however, an element of anxiety relating to the efficacy of fellow team members may arise, contributing perhaps to the evaluative component inherent in a training setting.

- **Experience of being observed by the client family:**

There appears to exist little in the literature that focuses on the issue of reflecting team members being observed by the client family. Andersen (1995:19) does state however, that it is essential that participants feel able to say and do what is natural and comfortable. The responses reveal that this is not always the case. For the respondents, the experience evidences both difference and similarity. This theme links closely to the one that follows, (i.e. regarding change in experience of being observed over time) and some of the respondents explored the two themes together. As with some of the comments in the theme explored above, team composition impacts on experiences. The range of experiences encompasses the following.

"Um bizarre! (laughs) … it was absolutely bizarre …".

Referring to a particular team leader the above respondent went on to qualify her statement.

" … she wanted us to communicate not just with words … she wanted us to act it out! She had this dramatic way about her, um, so we would act out what we observed … put on a little skit in a way … and I found that so hard because its not naturally me … I found that hard, to be performing, it was too much at too many levels, it was too much for me!".

While being able to see the value this may have for family member, particularly children, the experience proved too challenging for this respondent.

"... it wasn't an experience that I enjoyed, um, I didn't always feel real ... I couldn't always be myself, I couldn't say really what I wanted to say ... I felt like I was putting on a performance, and that's not me".

Developing a therapeutic style that is both personal and professional is a central developmental task. Goldenberg and Goldenberg (1996:365) explore the journey of professional growth which includes learning theoretical constructs and intervention skills, mastering specific interventions, and the discovery of a therapeutic style that is authentic to the self of the practitioner.

The potential for anxiety in the process of being observed was mentioned by some respondents.

"I think, initially it was a bit nerve-wracking, initially I had very little understanding of it and as I got a better understanding of what I was thinking and why I was thinking it, I think I got a bit more comfortable with myself ...".
For this respondent, better theoretical training for new family therapy practitioners may facilitate enhanced understanding – furthering her own studies was instrumental in the experience of competency and efficacy in being part of the reflecting team.
" ... from a family therapy point of view, I would have enjoyed it sooner, because I like to have a good theoretical base from which to work ...".

This viewpoint resonates with the researcher's perspective, in that the paucity of theoretical material provided for training at Family Life Centre contributes to a sense of inadequacy and anxiety for some practitioners.

"It was very nerve-wracking at first ... it was very uncomfortable ... I suppose it was having the camera, reflecting my thoughts about a family who was watching, how accurate they were ... hoping that they were going to value what I had to say, and hoping that what I say doesn't reflect badly on the rest of the team ...".

*"Initially absolutely terrifying ... but then you focus on the family and I was able to let go of that ... it got very much easier ... I think you owe it to the client at the end of the day, its not about **me**, its about the family ...".*

"Um, almost a sense of unease ... seeing the family for the first time or them seeing you for the first time felt uncomfortable ... um, a bit jarring ... because we had the continuity of having looked at the family for a whole hour, now they have to swap over and look at us and that, uh, felt a bit jarring, as though there was no flow of meeting us first perhaps ... knowing that we're there and all of a sudden four heads pop up and we're going to have our say ...".

Two respondents mentioned the issue of the extent of the reflections offered to the family.

" ... there's an awareness that we need to highlight the most important, or most obvious ... we need to highlight what we are going to discuss ... we give far too much information, and even if its all accurate information, all of value, its too much for clients because of where they're at or what they are able to absorb ... so to me, the team is improving in that process, being more useful to the clients ...".

According to Lax (1995:145-146), there are occasions when the team's reflections are not useful to the family, one of these being when the reflections are too long or too many ideas are presented. Clearly this is an issue of concern to the respondents above and below.

"At times, in the team, it's a case of who can get the most points across ... the most observations ... and that needs to be reigned in, to a few useful points for the family to go away with ...".

For this respondent, it is important to realise that at times the reflections offered to the family may not always be accepted.

"... however good the feedback, sometimes the family don't want it, don't get it".

One respondent had no anxiety or discomfort in being observed by the family, as her comment testifies.
"That didn't bother me .... I don't mind it, don't mind being in a situation where you have to comment or whatever ...".

From the reflections explored it can be concluded that the experience of being observed by the client family is not an easy one for most respondents, at least initially. This perception is mostly related to other factors, as explored above, and less to do the client family themselves.

- **Changes in experience of being observed over time:**

Some of the respondents linked this theme with their responses to the previous one, thus the theme has already been partially explored. From aspects mentioned above and the following, it appears that most of the respondent's experience of being observed became easier with time.

"... after a while it was no longer a big deal to me ... I was less conscious of being observed ...".

"... initially I was terrified, what will I say, how will I say it, will I get it right, so in myself there's a high anxiety level and the longer I do it the less anxiety I feel ...".

"It just felt a little easier, I felt less anxious ... but not completely un-anxious because each family's different, so a degree of anxiety always remains ...".

This sentiment was echoed in part by another respondent who had the following to say.
"I think each time it's a new family the same feeling is there, but as they get to know us, as we swap over and they say 'hi' or whatever it feels easier".

Two respondents commented on the issue of the generation of multiple perspectives by the team members, an aspect that may enhance professional growth.

" ... in the team you've got the benefit of different perspectives and different insights, and somebody would hear something I didn't hear at all, so that in itself obviously benefits the client, but it benefits you in your own personal growth".

"... because each one (team member) *can hold onto different things for different people and see if there is change over time ... those little nuances that one may fail to hear, the team could bring up and reflect and then that brings a different dimension ...".*

From the perspective of the researcher, one of the advantages and 'comforts' of working in a reflecting team is knowing that fellow team members will inevitably pick up on aspects that the primary therapist may miss in the dynamic and complex process that is family therapy.

One respondent reported her feeling of discomfort with regard to aspects of participating in the reflecting team did not improve over time.
"It got worse!".

Thus for most, but not all of the respondents, experience seems to bring a sense of enhanced confidence and lessened anxiety. In addition, the advantage of multiple perspectives for both the client family and the reflecting team members is an issue of importance mentioned by some the respondents.

- **General impression of participation in a reflecting team:**

Respondents varied in their general impressions of reflecting team participation. Some of the responses to this theme were positive, although a few respondents felt some ambivalence with regard to various aspects of participation, as the comments below illustrate.

"It's a superb way of working, if its used, more deeply ... it's as if you can't say certain things in case you offend the family, which means it doesn't allow for challenge ... its just

providing a mirror ... you can't really challenge the behaviour or anything to facilitate change ... and I find that incredibly frustrating".

According to Andersen (1995:22), it is safer to explore existing meanings with the family that to bring more meanings to complicate the picture. However, a 'stuck' family system may need new ideas to broaden perspectives and the task of the reflecting team is to create these ideas even if rejected by the family (Andersen, 1987:415). Andersen believes that the family will select the ideas that fit and which may pave the way for change.

"I've learned a lot ... where else would I have had the experience ... I've learned a lot about myself ... I think its very good to work with other therapists, brainstorming different ideas can be immensely beneficial to the whole process ... I'm not knocking teams, if its done properly ... but I would just work in a different way (in future private practice)*".*

"Its very interesting because I had assumed that we were all professionals in a professional field, so, that no ego's were involved, and I've learned over time that ego's are actually involved and I find that very difficult ... we can't focus on the family and their issues, that our own stuff keeps coming through ...".
For this respondent there is a sense of disappointment, even sadness that personal issues and egos can, at times, interfere with the reflecting team process.
" ... their own issues are there, are big, and in the room ... I didn't expect that, I just assumed objectivity because we're all professional and that the focus was on the family ... that's been a huge shock".

In the literature review (Chapter 3:180), the views of White (1990:76) regarding the expectations of those involved in training and/or supervision were discussed. While not specifically addressing the topic of personal ego's and issues, such expectations are closely related to the beliefs held by both parties concerning the nature of the therapeutic encounter and training/supervision. If there is a match concerning the expectations of

participants, a degree of comfort in the encounter will be achieved. However, such a match does not always occur and may result in conflict with resolution slanted in favour of the trainer or supervisor.

"Its something that, uh, you know if I think of all the different reflecting teams I've worked on, for instance with the other Unisa students (MA studies) *it was very different because it was much more controlled, and um, at Family Life Centre it's sometimes really scary because, um, they* (team members) *would sometimes say outrageous things and then what to you do with it ...".*

According to Young *et al.* (1989:72), performance anxiety is shared within the system, as trainees and experienced therapists contribute to the discussion as the family watches. All participants see team members struggling to make sense of the interaction between therapist and family members, which may enhance the gaining of a meta-perspective more readily. Differences of opinion among team members can be usefully explored through emphasising that these are in addition to, and not instead of or opposed to (Lax, 1995:162).

"... as an intern I think I wasn't just an equal member of the team, so my role was different from the staff ... it did move to more of a sense of a team, instead of they (the staff) *are there to observe us ...".*

Again, this reflects the perception of hierarchy and power within the team and the organisation. Biever and Gardner (1995:49) pose the question of how one trains people in a manner that suggests that knowledge is negotiable. Just as different families will respond in different ways to the same therapist, trainees will develop a different understanding of the supervision process. This theme is reiterated at several points throughout the reflections on various aspects.

Responses that reflect a positive experience for team participants are narrated below.

"I find it very, um, it has this wonderful support element, its fantastic to be able to listen to other people's point of view and ideas on theory, their insights ... perhaps a different perspective from one's own ... its nice to get other therapists points of view, for your own growth as well as for the benefit of the family ... its made me a better listener, you have to listen very carefully, so you have to focus your listening skills ...".

"Its very valuable ... being in the reflecting team, being part of it, gives you an opportunity to learn from other people and to see things in a different way and I think that's as much of a learning experience as anything else ...".

"It's a very positive experience, its very encouraging, not judgemental or condemning for you ... you're always free to give your opinion and even if people agree or disagree it doesn't take away the fact that you have an opinion and your insight ... it's a very comfortable scenario ...".

According to Du Toit (2002:34), experiential learning in the training context suggests that a postmodern approach which focuses on meaning and understanding as central to learning is preferable to the didactic acquisition of skills that have a modernist flavour of objectivity and 'correctness'. With regard to the client family, the respondent above expanded her views.

" ... I wouldn't say that you ever get to the stage of complacency and a totally relaxed state because you're dealing with people's (the family) *feelings, their life experiences, so you can never become too casual about it ... definitely not ... I think stress is a good thing for sharpening how you do things".*

Thus it appears that most respondents experience reflecting team practice as beneficial in terms of learning, personal growth and its value for the client family. However, some aspects of the responses above clearly suggest, once again, that team composition is a critical component of how reflecting team practice is experienced by participants.

- **Feelings typically experienced during a family therapy session (about the family, team, self):**

A range of feelings experienced by respondents during a family therapy session were explored. As could be anticipated, a multitude of perspectives were presented, with many similarities as well as differences.

Anxiety is a typically reported feeling experienced by the respondents, not only for themselves but also for fellow team members, and even for the family at times. The themes discussed below describe aspects of the respondents' experiences. One respondent recalled an incident where only the mother in a family booked for family therapy arrived, and her own experience of feeling *" ... quite shaken ... not a pleasant experience ...".*

"Often anxiety, and if you were behind the mirror watching, anxious for someone else ... I think you pick up on that ...".

"I think, obviously initially you feel very self-conscious and you are anxious to make notes or to note something, to have some kind of take on the family ... so there's a certain amount of stress and uncomfortableness ...".

A few respondents reported a feeling of relief when it is not their turn to be in the role of primary therapist, and sometimes frustration with team members, as the comments below suggest.

"... there's always a sense of relief when I'm not going to be the one with the family (laughs) ... in general, a big sweeping term – relief! (laughs)".

"Honestly, sometimes there is a feeling of relief that you're not in her (primary therapist) *seat (laughs) ... and there can be frustration with the therapist in there because you feel maybe they've picked up on the wrong point or something ...".*

" ... frustration that we, they, weren't getting it, weren't helping the family to make the changes they want ... sometimes anger sitting watching a therapist not grasping what's there, being the 'nice person' ...".

As previously mentioned, the idea of multiple explanations and descriptions is easily understood by trainees, however a tendency to either/or thinking or the 'best' idea remains. The process of reflecting team work illustrates the difference in meanings that people generate through dialogue. It is interesting for the researcher that the belief in differences in meanings, so important in working with the client family, does not always seem to extend to the team.

Again, for one respondent, the issue of team composition is relevant.
"About the family, humble ... about the team, irritability ... irritability and frustration".

One respondent experiences at times, a resonance from previous work with families, albeit in a different environment. Such a feeling reinforces for her that *"... my beliefs and my approach to family therapy, the values I have are confirmed ...".*

Some of the respondents explored the way in which work with families has the potential to evoke personal feelings and responses. Lax (1995:50) discusses the issue of situating comments within what has been observed and personal experience, thus bridging the gap between objectivity and subjectivity. His view is that the value of transparency and equality are brought into being through open dialogue that explores personal experiences that may have led to certain thoughts about the client family. Of significance to the researcher, is that the explorations reveal a difference in the position of the therapist regarding first- and second-order principles in family therapy, in other words, being an observer, and being part of the observing system.

"... I've been amazed how emotionally you are affected, being an observer, which I didn't realise would impact, I thought you would be more distant from it but you aren't actually excluded from being part of the system ...".

"I think what I try to do when I'm observing a family, is pinpoint for myself what my identification points are in each person, so that I can put my own stuff aside ... I try and identify who in the family is going to hook my stuff so I can separate that ... and be as objective as possible, but bearing in mind my feelings obviously do come into play ... sometimes its difficult to separate but I think acknowledging that that's my stuff frees you from it to a certain extent ...".

According to Haber (1990:378-379), experiential methods of training such as the reflecting team setting, may provide an opportunity to focus on the issues of the therapist and enhance awareness of how the self may interact with challenging family therapy situations. In the experience of the researcher, such an opportunity is critical for team members to be able to explore any issues or conflicts. However, the need to feel safe, accepted and not judged within the team could be factors that may inhibit such exploration.

" ... sometimes I knew in myself that, um, I was responding to a particular individual ... I was getting upset for that person, being in that role in their family ... sometimes you feel despair for them, because you can adapt and change your behaviour and it will result in something being different somewhere, but it will never take away the entirety of the pain ...".

In addition to this sentiment however, this respondent also feels that family therapy is a positive process for both the family and the therapist involved, specifically in that it has such potential for feedback.

"... a lot of the value of family therapy is that it creates an opportunity for feedback, both feedback to the therapist, feedback from the team, and feedback from the family as to how things are going and how they've experienced the process ... and that means you can constantly re-evaluate and assess what you're doing ...".

Feedback was also mentioned by one of the respondents, albeit in a less positive way.

" ... interestingly enough when we do the final feedback together at the end (as part of the reflecting team, being observed by the family) *my anxiety is elevated because at times*

I don't feel, um, not, uh, ***not*** *valued, but not trusted … so at times I've got into a position of self-protection where I monitor what I say …".*

According to Carlson and Erikson (2001:199), family therapists-in-training bring skills, experience, knowledge and ideas which are seldom validated in traditional training settings. For this respondent, peer discussion with colleagues helps her to understand and create meaning relating to her understanding of the family and her self, in an atmosphere where she feels less guarded.

"… we do peer supervision ourselves, alone, where we rehash what's happened … we're more free to say what we need … I think it may boil down to an authority thing, the hierarchy issue … ja, we're not seen as equals, not, um, competent enough".

Zimmerman and Dickerson (1996:115) suggest that reflexive thinking allows people to wonder about multiple possibilities for understanding experiences. A helpful way to do this is for reflecting team members to interview one another, raising questions about aspects relating to the client family interview, and creating space for new associations.

Positive reflections from the respondent's relating to their experiences are narrated below.

"… I find it very positive, I enjoy the intensity of it … the dynamic-ness of it … and you don't have to do it alone … I find being in a team much easier, less demanding …".

"Also, I think enjoyable … I enjoy working with families, that interaction, and um, challenge … very conflicted families challenge you to stay with them, to actually understand …".

"Very intense, being part of the team and being the therapist … excitement, curiosity …".

In conclusion, the feelings typically experienced by the respondents in a reflecting team context show much variation, ranging from anxiety, irritation at team members, personal affective responses to the client family, and enjoyment and excitement.

- **Incidents (positive or negative) that may have significantly influenced you during participation in a reflecting team:**

According to Young *et al.* (1989:73-74), the evolution of the reflecting training team is consistent with second-order cybernetic and systemic principles. The recursive nature of the therapeutic process is reflected in the relationship between trainer and trainees. All team members have a view of what happens in the session and identify with different parts of the system – they affect, and in turn are affected by the team discussion, which in turn can be affected by the family, thus a co-evolutionary process ensues.

As will be shown, many of the responses to this theme focus around aspects relating to being a member of the reflecting team, rather than on issues relating to the practice of family therapy in a team context. As has been explored on a number of occasions throughout the discussions on findings, the composition of the reflecting team seems to have enormous impact on the experiences of the respondents.

"Yes, one ... I was the therapist and for the life of me I don't know what the team said ... they took a theme and tried to narrative around it, and they went round and round ... it was an absolute waste of time ... and the family refused the team again, and I could understand!".

"... the influence was that team behind the mirror, and that feeling of being intimidated ...".

"I think a negative impact that occurred is that even when I have a gut feeling about something, I'm not always keen to express it ... so I will guard that opinion, for peer supervision, rather than saying it out loud (in the team context)*...".*

"... I said something in the reflecting team (during feedback to the family) *and it obviously came across as being quite, um, rejecting of the persons feelings ... and I remember* (the team leader) *saying whatever, and it made me more aware of the way I come across, and that was very valuable input, because I think it came from a good place ...".*

This respondent made a distinction between constructive and harmful feedback from team members, as the comments above and below illustrate.

"... whereas when (a fellow team member) *made a comment about me, that experience was negative, and it wasn't done in a good way ..."*

The importance of the reflecting team being a safe space, and of the fit and relationship between team members was reiterated by this respondent, as well as the respondent that follows, and is illustrated in their narrations.

"... I think also when you get together with your team members and you feel like they're interested in you as an individual, you feel much freer to participate, and much more comfortable with saying what you think ... you're not worried someone's trying to catch you out ...".

"A disagreement with a fellow intern ... just different points of view but its sad because the other intern left the team ... we didn't get to work with that ... different voices can get into conflict and voices can be ***so*** *different that they can't bear to be heard next to each other ... it could have been useful to explore it ...".*

What seems significant to the researcher about the comments above, is how the reflecting team itself becomes a system, with similar conflict dynamics to those that can occur in a family. This systemic view is shared by the respondent below, as her views illustrate.

"Well, obviously everything influences you ... if you have an experienced team, or if you have a team with new students ... so I think everybody in the reflecting team has some influence because it's a system ... sometimes you have people you know are reliable and wouldn't say things that are off the wall, and sometimes you don't ... it's the same behind

the mirror, sometimes you get someone who doesn't stop talking ... I think that talking behind the mirror is one of the things that gets me down, especially if its very negative ...".

Clearly for this respondent the issue of being disrespectful towards the family, even covertly behind the mirror, is a painful experience, one that has been mentioned in other sections by other respondents. With regard to a systemic view, Duhl (1987:74) states that systems are not only between persons, but within, and that any therapist must necessarily become aware of these systems within the self.

One respondent recalled an incident of something said to a family member by the primary therapist.

"... something jolted in me when she said that, I think it was something I would remember never to say".

Although a negative experience for this respondent, the learning component of team work is evident in her response.

More positive experiences that influence reflecting team practice are explored in the comments below.

" ... there's a sense that the more you experience it the bigger your repertoire of experiences are when it comes to therapy, so yes, every experience you have adds to that ...".

"From a positive point of view I've been exposed to people with completely different views and it's given me a different viewpoint of the family ... its given me food for thought ...".

"I think it's a wonderful experience to work with a team, to have many heads to think about the family ...".

For this respondent, picking up on aspects missed or overlooked by fellow team members can be positive for the family in that *"... it provides a much fuller space for the therapy,*

a bigger container for the whole family ... it's a wonderful experience if it's used correctly ...".

"I think the fact that our reflecting team leader was very non-critical, how she practices as a family therapist is exactly how she is with the students ... its about letting you grow ... that was very comforting ... and it takes a while for you to internalise that kind of permissiveness ... that was very freeing, uh, to be me ...".

Reflecting team practice has the potential to be experienced as extremely rewarding in terms of personal and professional growth, but also as very challenging, particularly with regard to relationships between team members.

- **Learning (skills, knowledge, self) from the experience of participation in a reflecting team:**

Despite an overall impression of the anxiety that participation in a reflecting team may engender, the comments relating to learning from the experience reveal it to be an extremely challenging and edifying opportunity.

"Tolerance ... I was actually quite surprised because the Christian thing is that there is one way to see or do things ... and uh, I've sort of broken right away from that, and that's a good learning thing ... in terms of skills, what I can do, um, I learned I can be quite creative, which was a surprise (laughs) ... I enjoyed that, its great! About the reflecting team, its amazing how many different angles you can talk about the family from ... its quite an amazing variety, ja, people often surprise you".

"About myself it helped me to be able to express something to a group of people in a family in fairly concise terms, because I tend to ramble on a bit ... it has forced me to summarise things, to make my points clearer ...".

This respondent, while valuing her training which provided a theoretical base from which to work, nonetheless believes growth is necessary in terms of being more eclectic.

"... I need to look more deeply at other theoretical approaches, and skills of working with a varied group of people, a very emotionally bonded group of people ... so you are prepared for any kind of eventuality ... expecting the unknown to become known".

Perhaps this last comment signifies a degree of insecurity in family therapy practice, and the hope that theory and experience will allay this? In the literature review (Chapter 4:213) Sussman (1995:16) describes a number of motivations or 'illusions' that may be part of the experience of the therapist's professional journey. One such illusion is the wish that training may allow one to become all-knowing and all-seeing.

" ... in terms of myself, the ability to be watched by people who are assessing you and not mind, to just get over it ... if I had been younger I would have been intimidated ... if I'd been fresh out of university I think I would have probably left (laughs)".

"You know, on a purely selfish level its learning to manage my own anxieties and I've had to do that at various levels ... because family therapy, out of the whole internship was the hardest part for me, although it was what I was most excited about ... that was going to be new territory ... so getting to a point where I'm as peace with myself and being effective with the family ... it's a positive experience".

"I think what family therapy teaches you is that, sometimes what you see across the mirror is exactly what you grew up with, and you actually have to, um, come to terms with that and accept that that's part of it ... so it teaches you that families and individuals are not infallible and are not all perfect ... it taught me a lot about myself as a therapist ... its more valuable to me a lot of the time than one-on-one supervision".

Sussman (1995:17) mentions a further illusion that may occur in a therapist's personal journey as being the hope of resolving family-of-origin issues. Satir (1987:21) suggests that in family therapy it is likely that at some point, the therapist will experience a scenario similar to his/her own family-of-origin. Difficulties not yet resolved will impact on the therapy, perhaps leaving the family stranded because the therapist him/herself is

lost. In the experience of the researcher, team members often share resonances from their own lives that coincide with aspects observed in the client family therapy session.

"I think you learn all the time, there's so many stimuli ... the therapist, watching her, family dynamics, learning from your colleagues and their insights ... how to correlate your insights into a useful message ... there's also learning your emotional state, when I see this or this upsets me and that doesn't ... why does it affect me so much .. on a personal level, your own generational issues or your own history being mirrored and to work through that, because it ***will*** *impact ...".*

The comments of the two respondents above illustrate their awareness of the potential impact of family-of-origin issues upon the self and the family therapy process.

For one respondent, learning centres on confirmation of the way she would like to practice in the future, while for another, it reiterates her sense of confidence.
"Confirming for me that this is not the approach for me ... it was good to know that the way I saw myself working was confirmed ... that was a good learning curve ...".

"... I've never been quite sure how I would handle a family, where people are joined through an emotional experience ... but I think what has happened for me, its elevated my own sense of competency, that I can do it and that I am able to contain 4 or 5 people in a room, um, without it falling apart ...".
As far as learning about families, this respondent reflected as follows.
"I've learned that people are amazing, just so different, and that there's no such think as the norm ... you work in such different ways that work for one but wouldn't work for somebody else ... I have to keep an open mind at all times ... and that the awareness and insight they (the family) *gain is often through something that's said in passing, you know, that may not seem profound to you, but it is to them".*

The theme of family diversity and family dynamics was one echoed by a number of respondents.

Some of the respondents remarked specifically on the issue of self and the importance of knowing the self, as illustrated by the following.

"... the self is the biggest thing you bring to the therapy, you don't come with a cookie cut-out approach ... the self is the biggest factor you bring".

"I think what I've learned about myself is my capacity to challenge ... I am a challenging therapist".

Therapeutic styles (discussed in Chapter 4:227) are explored by Gilbert *et al.* (1989:11) who make the distinction between styles of containment and confronting. Containment involves a focus on empathy and acceptance of the clients' feelings, comments, and actions and so on. This is the basis of unconditional positive regard, viewed as a core factor in the humanistically orientated therapeutic relationship. Confronting occurs when the therapist puts pressure on the client to talk about sensitive issues they may prefer to avoid, or to approach various feared situations or stimuli. Rigid adherence to either position may be inappropriate to the needs of different clients.

Thus to conclude, it seems that the experience of learning within the context of reflecting team practice is one that is perceived as enriching and enhancing on a number of levels, from skills, knowledge of family dynamics and diversity, to self-awareness and insight, and hence the capacity for reflexivity.

- **Ways in which participation in a reflecting team may have influenced your choice of theoretical approach:**

Dallos and Draper (2000:179) state that the practice of family therapy has replaced therapeutic secrecy with openness, direct observation and live supervision in a way which demonstrates the therapist's journey of change. One of the positive legacies of postmodernism is dialogue about the various approaches as different ways of explaining problems, rather than arguing about which is correct. Opinion on the influence of the reflecting team upon choice of theoretical approach showed variation. Two respondents

were quite emphatic that no influence had occurred, although one respondent feels that her approach facilitates understanding of the team as a system.

"No, the reflecting team didn't influence my theoretical approach ... but I use my theoretical approach in the reflecting team, because the team almost becomes like a family of its own, develops its own patterns of behaviour, its own hierarchy ...".

Others were less certain of the influence of the reflecting team, as the comments below illustrate.

"Not in terms of change ... um ... it might have solidified my thinking about working with more than one person, a system ... it might have confirmed for me that that's the better approach ... but no, not radical change".

"Um ... its quite difficult to say ... I think maybe tolerance (for different approaches) *... that influenced how I thought, how I saw things ... but I don't think the reflecting team really influenced ... maybe I wasn't quite as open to some because they didn't fit".*

The theme of eclecticism was raised by a few respondents, as one of the reflections illustrates.
"I will always have the person-centred approach as my base, and ... build on that, the rest will be eclectic ...".

For one respondent the influence of the reflecting team is more a confirmation that a blind adherence to a particular approach is not for her, her preference being as follows.
"... using what fits and what is appropriate for that particular family".

Three respondents believe that reflecting team practice does impact on theoretical approach, as the following remarks reveal. As can be seen however, the opinions differ in that one respondent experienced this as positive, one was more ambivalent, while for the last, it raises awareness of a less than ideal fit.

"I think you're definitely influenced by your peer group, your colleagues, the team ... because in sharing ideas there'll be agreement ... uh, I agree with this or disagree with that ... so they do shape your approach to a degree ... I suppose when you try things with a family or you observe something that's not working, you have to reflect that there are other options ... so yes, I think the experience challenges your approach all the time ...".

"Well, I suppose it teaches you that (certain approaches) *... not entirely effective or relevant when working with a system that is dynamic ...".*

"I think it scared me away from the narrative approach! Now that I think about it!".
Opinion on the influence of reflecting team practice upon theoretical approach appears quite divided, with some respondents believing it to be minimal or even non-existent, while others see it as more influential, albeit more or less positively.

- **Feelings when fellow team members evidence different theoretical approaches in family therapy practice:**

According to Dallos (1997:xii), theories come and to in the field of family therapy, which emphasises the need to reflect critically on these theories, as well as to develop a reflexivity that facilitates critical thinking and practice. Merry (2002:29) suggests that conditions of worth are acquired through learning that we are acceptable only if we think, feel and behave in ways that are positively valued by others. From the perspective of the researcher, the implications of this for family therapy practice are evident, particularly in a training setting and in reflecting team practice, where a feeling of being judged and not accepted by the team may give rise to incongruency within the therapist, making it difficult to be authentic in the therapeutic encounter.

The exploration on the use of different theoretical approaches evoked mixed feelings. Some respondents feel positive about the use of different theoretical approaches by fellow team members, as the following statements reveal.

"Really interesting ... different paradigms can be an interesting way of viewing something that I interpreted differently".

"Well, if I feel that its working well, then I feel I must remember that, its something to learn from and perhaps look deeper into ... conversely, if I question the benefit ... see that it doesn't work, then it confirms it for me".

Despite some initial discomfort, the respondent below feels positive about multiple approaches.

"Initially, it was sort of strange ... but you know, people are different and I think that's one of the good things, people come in with different ideas ...".\

For this respondent, the benefit of difference is good for the family as well as the team.

"... the family can take what they want ...".

Some responses illustrate a theme of similarity regarding approach used among the reflecting team members.

"I think our team is quite similar in our approaches ..."

Difference, for this respondent, is experienced as follows.

"... but if there is a difference of opinion I think its easily accepted because the team's stronger for the diversity ... it doesn't have to be completely the same ... so I think different approaches and different ways of doing is positive ... I think from a learning experience I'm so unfinished ... still trying to find my way, what works for me, so I'm open to other people's opinions and approaches ...".

"... I wouldn't say that I necessarily observed people doing something that's completely different to what I would have done ... maybe that's why it's a positive experiences for me ... I felt like I understood, and I had something to contribute ...".

For this respondent, the experience of radical difference may have resulted in a more personally challenging ordeal.

"... whereas maybe if something was done in a completely different theoretical frame I would have felt under pressure to, um, be responding in that way, to be thinking about issues in that particular way ... I probably would have felt uncomfortable, less effective or ill informed ...".

The composition and dynamics of the reflecting team once again impact on the experience of the respondents regarding difference of theoretical approach. The issue of team power dynamics and hierarchy are seen as significant, particularly but not exclusively regarding the experience of being an intern or student.
"There isn't space for it ... the therapist can be however they want to be, can use any theoretical paradigm, but the feedback by the reflecting team has to be a certain way ... that's where there's inflexibility".

A study on therapist development by Hanford (2004:51) suggests that the influence of second-order cybernetics on training emphasises a non-expert stance, wherein trainer and trainee co-construct understanding and value multiple perspectives, thus challenging issues of power, control and hierarchy.

"Again, the power imbalance ... the approach the supervisor took became ***the*** *approach ... it was subtle and maybe it was just me ... it wasn't that one was saying black and the other was saying white, it was never that extreme ... it wasn't always there, just times when I kind of felt, just don't rock the boat".*

"... I think it was (the supervisor's) *approach ... the reflections made me feel uncomfortable, it made me feel like it was too far out of, um, familiar ground, safe territory ... I wasn't confident enough to say, um, no, maybe not ... so discomfort and maybe anxiety ... discomfort is the word".*

"Quite difficult ... particularly if it's a person in a higher hierarchy ... um, the openness for change may not be there, so criticism may be harsh ... I think had I not had a strong sense of self it would have destroyed me...".

For this respondent her own self-awareness has enabled her to retain a sense of confidence and integrity in practice. Clearly however, the experience of criticism of difference within a team has the potential to be crippling for the less secure participant.

As can be deduced from the responses above, differing theoretical perspectives may be experienced as enriching by some respondents, but as a prescriptive by others.

- **Ways in which participation in a reflecting team may have fostered a higher level of self-awareness (personally and professionally):**

Hanford (2004:47) explored aspects relating to counsellor training and education, and suggests that trainees learn through observation of the observations of others, in other words the therapist becomes part of the observing system. As the following comments testify, responses to this theme were fairly unequivocal in confirmation that reflecting team participation enhances self-awareness on various levels and through various mechanisms.

One respondent believes however, that therapeutic practice in general enhances self-awareness, rather than specifically participation in a reflecting team.
"... it's not for me that family therapy stands out as better or more influential than other experiences ... you always have to be very aware of yourself in the work that you do ... I think initially my levels of self-awareness (in the reflecting team) *were higher, but really in the wrong way, in terms of being watched (laughs) ... but you get past that, so that was actually negative self-awareness, but positive in the sense that you get over it ...".*
However, this respondent went on to add that participation in a reflecting team enhances self-confidence, as well as awareness of the uniqueness of families and family dynamics, and that *"... personal and professional awareness kind of tie in ... I think in this job you have to have high levels of self-awareness ...".*

Conversely, for other respondents the experience of participation in a reflecting team influences self-awareness more than other methods of intervention, as the following reflections suggest.

"Ja, absolutely, you know when you are part of the team, you're considering how you are in the room, you're thinking, how am I being observed ... so it engenders a far greater self-reflection ... it makes you think about your effectiveness ... your stance ... how you are coming across ... how you choose your words ... whether you're giving each member of the family equal voice ... you don't get that to such an extent in a one-on-one setting ...".

"Ja, definitely ... because you get an opportunity to observe what other people do and say and sometimes you know that's what you also do, so you can see whether that does or doesn't work ... it triggers stuff that maybe you never thought was pertinent or had much significance ... it probably fosters more self-awareness a lot of the time than an individual process".

"I think I use every opportunity to develop self-awareness so ja, in a way it has increased my self-awareness of the way I am with a family, because you're obviously being seen through someone else's eyes and how you are in a family ..."

"Definitely, in my personal capacity, the ability to listen to a multitude of inputs at the same time and to be aware of the emotional levels around you, the body language of many people ... you have a much more panoramic view ... I've become much more aware of being a member of a family ... you know you belong to a family, but your role isn't often clear or even thought about ... my role as a mother, wife, sibling, I've given much more thought to that ... its made me look at my past and my family-of-origin more intently and less scathingly perhaps ... less critical, more accepting, you look at things with more compassion ...".

"Definitely! I think it allows for constructive criticism, it allows for constructive validation ... we see who we are in comparison to others ... and it builds confidence".

"I think, yes ... I think you can't take part in a reflecting team and not become more aware of your self on both levels (personal and professional) *because if you are with a*

family and you have a team of peers observing you're more keenly aware of what skills you use and how to use them, and so you become more aware of yourself, and your interaction, and how you relate to people ... you become aware of your own values, your own ways of seeing things that affects other people's ways ... so you do become more aware, um, just through interacting with all these people".

For one respondent, despite an initial experience of *" ... self-consciousness about my mannerisms ..."* and feeling as if she was *"... performing in front of an audience ..."* the overall sense is that participation in a reflecting team enhances self-awareness.

The opportunity of the post-family therapy session consultation was mentioned by one respondent as valuable in enhancing self-awareness.
"To be honest, the benefit I gain is after the counselling session, being able to talk about it, what you experienced, what went on ... and then to get advice or to ask about what I did or what I did wrong, or whatever ... my biggest learning experience I think is afterwards, being able to discuss ...".
This respondent also elaborated on her experience of participation in the reflecting team
"... you're gaining from your insight of the family and your experience, as well as theirs (team members) *... so it's a wonderful collaboration".*

As previously mentioned, Young *et al.* (1989:72) explore the issue of the use of the reflecting team, collective responsibility and the experience of a sense of losing control of the process and content of the therapeutic encounter. It would seem that these issues are not in the realms of experience of the respondents who touched on the topic. Two respondents specifically mentioned the issue of support by team members.

"... in a way knowing that if I miss something the team is there and they're going to catch it, so that they can be a support if I miss something that is vital ...".

"... its such a wonderful experience to have the support of a team, where they're actually working with you ... I feel that's a very positive support ... and in what they bring out, I

don't feel negative if they picked up something I didn't … I just feel it adds to the whole …".

In conclusion, the overwhelming majority of the respondents believe that reflecting team practice has a definite and positive impact on the enhancement of self-awareness, both personally and professionally. In addition, having the support of a team of colleagues was valued by some.

- **Further comments:**

A number of respondents added further comments to the theme of reflecting team participation.

"Well, what I think is unique is that it makes you think about the ethics of the reflecting team … I think we need to do a lot more of educating the family, um, preparing them, not just on the phone before they come in, and not just the one person who liaised with Family Life Centre …

For this respondent it may be more ethical to allow the family the opportunity to experience reflecting team practice and then decide if this feels right for them. In defence of the way family therapy is practiced at the Centre, families are always at liberty to refuse the team, recording of the session, and so on, at any stage of the process. Concurring with the respondent however, is the researcher's observation that the initial session often seems to be experienced by the family as very strange, even something of a shock, despite adequate preparation.

" … I think as a way of supervision its par excellence, you can't get a better way of supervising the process".

Biever and Gardner (1995:55) suggest that while the use of reflecting teams is valuable in training, they are not sufficient to meet all the training needs of trainees. These authors suggest both group and individual supervision complement the experience of participation in the reflecting team, through focusing on learning and experience.

"I think it's a very useful way of working ... I think there's a huge richness in the reflecting team that you miss when you don't have it ... but uh, I also think that on the other end of the scale it can become more of the same (for the family)*".*

In addition to seeing the value of reflecting team practice, the issues of practicality and suitability were raised by some respondents.

"I think it's wonderful, but it's very expensive to have that degree of expertise on one family ... I don't know if it's practical for everybody ...".

"I think that it's extremely valuable, extremely useful ... but it's not always practical in that there are five people holding the family, not just one ...".
This respondent went on to add however,
"... being part of the team has been really an amazing experience in terms of gaining more from it than just sitting and being bogged down in a family with a lot of issues, where you become emotionally entangled and can't separate ... and become part of the system".

"I think it has value, and there are people who obviously work well within that framework ... certainly the experienced therapists have a very good connection and gelled, and it works well ... it can work and be positive ...".
This perception was coloured however, with her experience as an intern and position in the team.
"... there was always a bit of, uh, a barrier there ...".

For one respondent, the experience of reflecting team practice may not suit all families or all therapists.
"It's really not everybody's cup of tea, for both family and therapist ... being part of a reflecting team is not for all therapists"

Most respondents believe reflecting team practice to be an invaluable experience for both therapist and family, although some reservations are felt with regard to issues such as ethics, expense and practicality.

5.4.4 Perceptions, Opinions and Experiences Relating to the Self in Family Therapy Practice

The following themes explore the perceptions, opinions and experiences relating to the personal and professional self of the family therapy practitioner.

5.4.4.1 Personal self

The development of the personal and professional self is a continuous process of reflexivity that is unique and specific to every practitioner of family therapy. It is not the intention of the researcher to suggest a path to follow on this journey, merely to illuminate its complexity and highlight the necessity of undertaking the task. The aim of this section was to raise awareness of the significant impact of family-of-origin and family-of-procreation issues upon family therapy practice, rather than a gratuitous curiosity about the personal self of the respondent. The researcher felt honoured and privileged to experience the trust, openness and honesty shown by the respondents in reflecting on these aspects of their lives.

- **Description of family-of-origin/family-of-procreation:**

McGoldrick and Carter (2005:28) state that the development of a mature, independent self requires an appreciation of our interdependence on each other, and that the "…connected self…" is based on recognition of the interdependence of people and is seen as critical to the development of psychological health. Berger (1995:316-317) explored the impact of his family-of-origin upon his career choice, and came to the realisation that many of his stressors and frustrations regarding his work were paralleled in the dynamics of his earlier family life. While family-of-origin issues remain relevant to professional practice, the sense of perpetuating long assigned family roles needs

resolution. Duhl (1987:74-75) too suggests the significance of knowing the systems within the self, being aware of one's thinking and beliefs relating to the stages of life, exploring the myths, rules and stories of one's own family and others in order to become aware of how we get hooked into certain scenarios and thus risk becoming reactive within the therapeutic encounter.

The respondents preferred to verbally describe their family situation, although two sketched a quick genogram while discussing. A summarised discussion of the family descriptions follows.

Respondent 1: This respondent is an only child in her family-of-origin, growing up in the United Kingdom – her father is deceased while her mother still lives in their country of origin. In her family-of-procreation she has been married twice, with two adolescent sons from her first marriage.

Respondent 2: This respondent is the middle child of three in her family-of-origin. Her father passed away when she was in her early twenties. Her family-of-procreation consists of her husband and two young sons.

Respondent 3: The family-of-origin of this respondent was composed of parents who both came from very large families, however there was no contact at all with the extended family on her father's side *"... so there's almost like half a family ... we don't have roots from that side ..."*. She is the youngest child of three. Both parents are deceased, with her father passing away this year. This respondent is in her second marriage, with three adult stepchildren.

Respondent 4: In her family-of-origin, this respondent is the oldest daughter of two siblings. Both parents are deceased, with her father passing away this year. The respondent is married, with a daughter and son in the life stage of late adolescence/young adulthood.

Respondent 5: This respondent is the youngest child of three siblings in her family-of-origin. Her father passed away when she was an infant, and her mother passed away two years ago. She is married with two adult sons, and one adult daughter.

Respondent 6: In her family-of-origin, this respondent is the middle child of three siblings. Her mother suffered from depression, relating to the trauma of relocation from their country of origin, and committed suicide when the children were of school-going age *"... the family broke up, we were put in boarding school ... we* (the siblings) *became the family"*. Her father currently lives overseas. The respondent is married, with one adolescent son.

Respondent 7: This respondent is the oldest child of four siblings in her family-of-origin. The siblings are all between four and five years apart. She was born to young parents " *... in complicated circumstances ... my parents had to get married ...".* She is married with a young son and daughter.

Respondent 8: In her family-of-origin, this respondent is the oldest child of three siblings. Her parents and brother currently live overseas, and she grew up with no extended family in South Africa. She is engaged to be married.

Respondent 9: This respondent is the youngest child of three, respectively eleven and eight years younger than her siblings. She is married with an infant daughter.

Themes of loss relating to death, divorce and family dispersal are evident in exploration of the respondents' family situations.

- **Role in family-of-origin/family-of-procreation and feelings regarding that role:**

In an exploration into the backgrounds of therapists, Goldberg (1986:53-55) suggests that the helping professional tends to observe and be reflective, wondering about other people's motives as well as their own, and has often been cast into the role of helper or nurturer in their family-of-origin. Family position also plays some part in the role of

family nurturer, with many therapists identifying themselves as the dominant sibling. A further factor appears to be experience of distress in early life (e.g. illness), periods of loneliness and sometimes loss, which develop a heightened sensitivity to others (Goldberg, 1986:57-58). Thus, in choosing a career in the healing professions, the therapist in adulthood 'chooses' the educational and life experiences that allow him/her to feel more adequate in dealing with human suffering. Goldberg (1986:59-60) further suggests that for many practitioners, their clients provide a "…psychological route…" to the riddle of their own family-of-origin.

The respondents were amazingly insightful and frank regarding their roles and feelings in their family situations. What was interesting for the researcher was the change in pace and tone of voice of the respondents at this point. Many of the comments in the dialogue process were spoken much more softly, and were thoughtful and tentative in presentation. The rewards and challenges of the roles played by respondents in their family situations are clearly evident in their narratives.

"... I was always the person who wanted to try and make things right ... a nurturer, looking after things, wanting things to better, and healthier... all of that stuff ...".
For this respondent being the oldest sibling was experienced as distancing in that *"... the gap was quite big, so my sister and brother were closer ... in a lot of ways I was kind on the one that was on the outside ...".*

"... my role was one of social worker, rescuer, facilitator ..."
This respondent was very aware of both the difficulties and secondary gains related to playing such a role in the family, *"... struggling with the level of dependency* (of family members) *... but enjoying the power (laughs softly)".*
For this respondent however, this role has changed and is not perpetuated in her family-of-procreation. The respondent below also shows awareness of the complex pros and cons that certain family roles entail.

"Peacemaker (laughs) ... especially in my family-of-origin, um ... and in my family now, well I'm the mom, so you know ... everything (laughs) ... I often feel frustrated (as peacemaker) *... but it can also be quite rewarding ... its quite nice having the connections with both sides ...".*

"... to a degree I was a parentified child, because I acted like a parent to all the kids ... because of the age difference I always had a very strong sense of responsibility ... my parents are only 20 years older than I am, so I don't have a typical parent/child relationship with them ... I was too responsible, too serious in some ways ...".
In her family-of-procreation, this respondent enjoys her roles as wife and mother, having to some extent, her sense of responsibility alleviated in that her husband is also the 'responsible' one in his own family-of-origin.

One respondent describes her role as close and supportive sibling. The events and dynamics of her family-of-origin are experienced as she describes below.
"... the children (herself and siblings) *became a unit ... my father feels like an outsider ... the bond is not great ... it shook the unity of the family, from relocating, to mom's suicide, to having to cope on our own ... kind of being unparented in a way ... left to my own journey of healing, of finding out who I am and what do I want to do with my life ...".*
This journey is reflected in her family-of-procreation, as the following remarks suggests.
"... my family-of-origin grew me to be who I am today, to where I am today ... so it was important for me to then, in choosing my new family, to find someone who would be OK with what I need to be ... I think because I was rebelling from my father and what he expected his daughters' to be like ... I wasn't going to then seek a life partner who wanted me to play a role as well ...".
For this respondent, the acceptance of her 'self' by her family-of-procreation allows her to continue on her journey of personal and professional growth. Complicating the picture however, is a certain tension with a father who still wants to define the respondent's role to some extent, which compels her to *"... police the boundaries ... and that's tiring and frustrating ...".*

"... in my family-of-origin, I was the eldest ... I had a role of too much responsibility because my mother was sick, she was always sick from the time of my birth ... in fact I was blamed for her sickness, because she had a thrombosis and she was never well after that ... when my sister was born four years later I did have the role of taking on quite a lot of responsibility, for my sister as well ... my sister always said she had two mothers ..."

For this respondent, there came a time of rebelling against this designated role, of challenging it but with difficulty that played out in her family-of-procreation, as the following remarks suggest.

"... my role as a mother was fraught with anxiety at first because I was determined not to be the same sort of mother as my own mother had been ... so without a proper frame of reference to work from its quite difficult to invent yourself ... you find yourself reverting back to what you know ...".

Resolution of this difficulty came with time for this respondent, although the caretaking role as older sister continues.

"... I was in a caretaking role when we were little, but with my sister I still have to take care of her ... she developed multiple sclerosis ... um, she is married, but I'm her emotional support ...".

"... my father was an alcoholic and my mother was deaf (from diphtheria at age 7) *... me being the youngest I became her 'ears' ... hence my good auditory memory ... and being able to, ja, hear five people at once ... I had to develop that* (skill) *... I was the people pleaser, my sister was the perfect one and my brother was withdrawn ... so I was the clown and the people pleaser ... I kept everybody laughing and happy ... because there was always heightened tension".*

For this respondent a role change has occurred in her current family, which consists of husband and stepchildren (all adult).

"... in my family at the moment I'm very much the withdrawn one ... I don't have much to do with them (stepchildren) *... I get on best with the youngest ... um, I prefer the withdrawn role, because the clown ended up being the stupid one ... which gave the family license to, um, make me the scapegoat ... whereas now I am the scapegoat for*

nothing … the negative is that they tend to walk over me, not consider me … if I do make an opinion its dismissed … its less pressurised being withdrawn, I understand now why my brother did it … it's a lot less responsibility, for keeping the family happy".

"I'm the responsible adult (laughs) … in both (family-of-origin and of procreation) *… it comes to me naturally … its not even something I question … I do get a bit irked sometimes when my siblings come to me if things have to be sorted out, especially now studying as a psychologist … there's a perception that I've got it all together (laughs)… that irritates me a bit at times …".*

Although not in the same context, Madigan (in Lax, 1995:148) describes how reflecting dialogues may give implicit sanction to the idea that the therapists are neutral, more "…together…or are more highly evolved…" than the family specifically and people generally, and know what is best for clients. The researcher is of the opinion, based on personal experience and the comments of colleagues, that the scenario of friends and relatives requesting emotional support and 'advice' is not uncommon. This respondent went on to describe how her role came about and how it was resolved for her.

"… my dad died when I was 23, so my mom was left widowed quite early … then the responsibility kicked in hugely … but I took it on myself, it wasn't expected of me … but suddenly I was having to fill that gap for her … I was very young and I felt that's what I had to do … it was guilt driven, a guilt thing … with age and experience and studying you realise that actually you can't, and so I've let go of that … at the end of the day we are all responsible for our own lives and choices …".

"… definitely a caretaker … I was the only child with two fairly emotionally absent parents … I felt like I was parenting them … always felt like that …".

Thus it can be concluded that the views of Goldberg (1986:53-60) expressed above, relate strongly to the experiences of the respondents in terms of their role in their family-of-

origin and of procreation. The theme below resonates with relevant aspects as already mentioned by Goldberg.

- **Origin of desire to help others:**

It was explored by Goldberg (1986:5) (in Chapter 4:212) that those who are called to the healing professions tend to have an intense interest in learning about themselves. An ongoing curiosity about examining one's own life and the development of personal growth provides impetus for interest in a conscious examination of the human condition. The view of Keith (1987:61) concurs with that of Goldberg, in that many therapists are drawn to the profession in an attempt to understand and deepen the connection with the self.

According to Viljoen (2004:39), motivation for entering the field of counselling may centre on the conscious and unconscious hope that personal needs will be satisfied in the therapeutic relationship. Nevertheless, Viljoen (2004:40) states that it is inevitable that the counsellor will look for need satisfaction in the professional context. Lack of awareness and insight into one's motives is clearly hazardous, both to our selves and to our clients, hence requiring a continuous reflexive attitude with regard to our work.

The findings relating to this theme are clearly and perceptibly linked to the experiences of the respondents in their own family situations, as the observations below elucidate.

"I think probably because of (daughter) *... because you know, uh, with her difficulties I became aware of, I went to see at therapist at one of the schools she went to and became aware of things in my family ...".*

This respondent came from a family where the women were high achievers in professional or academic positions, which impacted on her initial career choice.

"... I was sort of just expected to do science, so I did science ... and so I expected her (daughter) *to achieve and it sort of shook me ... it affected how I related to her ... and it took a long time to accept ... from that experience I developed more empathy for people".*

" ... I think the desire was, I suppose stemmed from wanting people to have skills to be happier, in families ... and because of my own experience, of what was going on in my own family ...".

This respondent had the early experience of childhood friendships with a family very different from her own, which illustrated for her that there were alternative ways of being a family.

"... I was fortunate to have twin friends in a very close family, so I spent a lot of time with them ... and that instilled my desire for family work ... because this was where people could heal ...".

Some of the narratives illustrate the theme of helping as being a natural part of the person, going back even to childhood.

"...its, what comes naturally for me ... and it's not appropriate to do it with your family and friends (laughs) ... its just a natural progression, it's the way that I am in the world ... it absolutely invigorates me ... it drains me as well at times, so I manage it".

"I think a lot of it ... I've always cared ... and I think as an oldest child maybe I get tied up in that ... and being a Christian there's a sense of, uh, wanting to be there for people ... I've always had a concern for the underdog ... I don't know if I ever went out to be the saviour of the world, it was never that ... but often people would speak to me ... so it's a natural progression ... it sort of just evolved and it seems to fit ...".

"When I was in grade 1, I used to write stories about the poor people on the street ... so the origins of caring go back to early childhood ...".

"I think it was ... I wasn't political at the age of 17 but it was a decision, a kind of orientation towards wanting to make a difference in the country ... I'm a person with lot of empathy and understanding for people in difficulty ...".

For this respondent, her own childhood challenges impacted on the choice of career in the helping professions.

"... I've grown up in my life always having a difficult, um, not in relation to my family but as a person ... I was born with a dislocated hip so I could only learn to walk when I was two years old ... as a child I was epileptic... I changed a lot of schools ... in high school I was probably quite depressed, that kind of stuff ... my decisions, maybe unconsciously, were informed in that way ... if you are a person who has had stuff in your life that hasn't been easy I do think you're better able to empathise ... its somewhat innate ... but that also doesn't mean that people who have had problems necessarily always make good therapists, or have empathy ...".

Some respondents mentioned other career decisions and paths, both in the helping and non-helping professions, in their journey towards family therapy practice.

"That's interesting because when I first started studying I was doing teaching ... I wanted to be a geography teacher ... psychology always fascinated me but it clashed at university in terms of the timetable ... I then taught and did a bit of training and got very bored ... then, being pregnant I was going to be at home, so, I needed to keep my mind going ... I picked up psychology 1 through Unisa and it hooked me ... I never intended actually to become a psychologist ... it just drew me ... its kind of as if I've found myself ...".

"I think the origin is that I had a sick mother ... being a child with a sick mother there was always a sense of helplessness, and not being able to do enough which I think compelled me to learn how to care, to take care more adequately of those around me ... I mean I started off nursing ...".

One respondent referred to the journey undertaken in her own therapy and the healing outcome of this.

"... in doing my own work, own therapy ... in dealing with my pain, my father's violence, and my first husband's emotional abuse ... healing myself from that ... its difficult to be much use as a healer unless you've had to do your own healing ... it's a job I have to do in this lifetime ... its seems unavoidable".

As mentioned above, it seems that the issues of loss, distress, family position and so on explored by Goldberg (1986:53-60) are evident in the reflections of the respondents.

- **Skills or abilities relating to helping others developed in life:**

Goldberg (1986:60) proposes that the struggle with suffering is a universal human condition and that denial of one's own suffering poses a problem for the client in his/her own personal journey of suffering. Personal struggle is necessary for the practitioner's growth as a therapist, and serves as a resource for the client (Goldberg, 1986:61). As can be surmised, different and similar themes were evoked in the exploration of the skills or abilities the respondents feel they have developed in their lives. One of the shared aspects mentioned, is the skill of listening, as the comments below illuminate.

"I think the ability to listen really, has been my greatest gift ... because not only do I hear the words, but because I used to listen for my mom, I used to listen to the nuances, and tone ... I would filter for my mom what was being said, if it was hurtful for her ... so I learned an incredible ability to understand nuances, tone, and work with my gut ... its taken me a long time to actually trust my gut, but I work a lot with it ...".

"Well, I've always been a good listener ... I've been told I'm a good listener, um, from early on ... friends and family have come and dumped on me ... as I've gotten older I think I've learned to put boundaries in place ... because you've got to protect yourself ...".

This respondent also mentioned the importance of life experience as necessary to work in the helping professions. Goldberg (1986:6) suggests that effective practitioners utilise their own life experiences as a major source of expertise in guiding others on their journey.

"... I wouldn't have been able to do psychology straight from varsity because life experience, having had a family, being married, having your own children ... all of those kind of enrich your own experience and help you to be able to relate ... so I think age, although not a skill, is, um, made it more possible ...".

"... I think I had, even before I was trained, like an ability to understand what people were saying ... I was always the person that people asked for, kind of ideas, or whatever ...".

"Listening ... I think I've become more and more confident over the years ... I've been confident in my family but we grew up isolated on a farm in the middle of nowhere, so I think in my peer group I was more quiet ... so I learned to listen ... and I suppose, that skill developed more than others (laughs) ... and I think empathy to a degree...".

The skill of empathy was mentioned by a number of respondents.
"Empathy ... and also the ability to think on a systems level ...".

"... understanding ... understanding and caring, and hoping that would change a situation...".

Other skills mentioned by the respondents include the following.
" ... mostly dealing with people different levels, from different walks of life ... without being the expert, without being prescriptive about change ... that's given me a lot, a lot of learning ...".

"... self containment! I have my own life, and feelings, and feeling something, containing it and then knowing what I'm feeling in the room, and if its my feeling, putting it down, if it's the other person's feeling, using it!".

For one respondent, her artistic skills have been significant in her own development as a family therapist. She believes that her past teaching efforts had a therapeutic effect upon the recipients, albeit that a therapeutic outcome was not the primary intention at the time.
"... when teaching art ... I didn't realise it at the time, but it was often an informal form of art therapy ... I had a lot of cancer survivors in classes I taught ...".
This respondent also believes in exploring other forms of alternative healing that have been part of her own life experiences.

One can assume that the respondents have been on a journey of skills training in helping throughout their lives. Important aspects mentioned are listening, empathy, life experience, confidence and the ability to engage with people at many levels.

- **The importance of developing these skills:**

Zeddies (1999:231) states that the relationship between a therapist's personal and professional identity is continuous, reflecting a dynamic relationship between what is meaningful or significant on a personal level and the theoretical/technical aspects that are learned and practiced. The importance respondents place on the development of their inherent skills shows, in general, a shared theme of significance. An aspect mentioned in the theme directly above, was commented on by another respondent, and for her, the importance of alternative forms of healing, especially the development of intuition, was emphasised. Comments on the importance of skills development in relation to a career in the helping professions are illustrated in the following.

"Very important ... I just feel that you can't stop learning ... um, even if its not concrete learning in books and things, but the learning from experiences ... analysing yourself, how can I do it differently, how can I do it better ... learning is important, and also learning from my weaknesses ...".

"I think it is important ... I think people are a lot happier doing things that they are good at ... so being able to follow a career in something you feel you already have some knowledge or experience in ...".

"Critical ... and ongoing ... it's knowing the self in relation to the other...".

"... you need them ... you absolutely need the skills ...".

"Its very important to me ... it's not something that I just regard as a job ... really, its part of who I am".

Regarding the issue of therapeutic intervention being a job, another respondent had this to say.

"Its important for as long as its good for me … at the end of the day its also a job … it is fitting for me but its also a job that, at a basic level needs to meet my needs financially … I've invested a lot of myself but I'm no martyr, I'm no do-gooder, and I'll continue doing it for as long as it continues to fulfil me and meet my needs …".

One respondent believes that ongoing skills development *"… gives me a sense of confidence and self-esteem …".*

"That's an interesting question, because um, I think in order to grow, these (skills) *are part of the equation … so from that point of view I would say it's really important …".*

This respondent went on to suggest that it is not only the development of existing skills that is important, but also building a repertoire of other skills. Family therapy is experienced by this respondent as a *"… challenge…"* which requires many skills.

In conclusion, the respondents believe that skills development, both innate and acquired, is essential and ongoing.

- **Experiences in life that invited entry into the field of family therapy:**

The concept of the 'wounded healer' (explored in Chapter 4:216) refers to the personal hurts and wounds of the therapist that motivate not only the choice of vocation, but also the power to heal (Viljoen, 2004:28; Miller & Baldwin, 1987:139). A number of similar themes emerged from the dialogue around this theme, with the obvious difference being the personal life experiences of the respondents. For some respondents, family therapy was an option or requirement of internship or training, but one that resonated with personal interest, as the comments below indicate.

"Well, it was just an option (at Family Life Centre) *um, I must say I was quite keen to do it because its part of my belief system ... because I think the family is the building block on which everything else depends ... and so few people do it!"* (family therapy).

"I think it was mostly my honours studies through Unisa ... um, that was the root, the foundation ... for me what was an immediate connection or an immediate fit was the thinking that there doesn't need to be an IP (identified patient) *... we don't need to scapegoat one person, we don't need to pathologise ... there really can be, um, another way of looking at people in a way that doesn't further make them 'patients', make them sick ...".*

"Well, if I think of my own family-of-origin, my dad dying when I was 23, the impact of that on my family was huge, dealing with my mother, dealing with my own grief ... you know, that whole being strong for her and she's being strong for us ... we didn't actually handle it very well now that I actually think about it ... we grieved separately and away from each other ... well, that's not necessarily what invited me into family therapy because it was just part of what I had to do (intern requirements) *... but having had an experience of trauma or crisis in my own family I was better able to relate to a family in crisis ... but having said that it doesn't mean as a therapist you have to have been through everything your clients have been through ...".*

"Um, ja I think I sort of fell into it, in my masters course ... I hadn't really given it much thought before ... um, wanting to work with families was there but I never really thought of the practical implications of it until I experienced something like working in a reflecting team ... how powerful that is ...".

"Because I was doing my internship here, (at Family Life Centre) *it was offered as a choice ... I chose to do it for the experience which I knew would be invaluable ... and because I had come from an uncomfortable family and I had a sense of identifying with a family that doesn't function well, and also to improve my ability to function, um, to improve the function of my family ...".*

The theme of growing up in a less than ideal family was one shared by a few respondents, as the comments above and below suggest.

"Growing up in a family probably labelled dysfunctional now ... with a mother and father who were incapable of parenting to any degree ... being a mother myself ...".

This respondent echoes the comments of the one above, in that she needed to understand the functioning of families related to her own life experiences.

"... what was it that made a family functional, a safe place to live, what distinguished one family from another ... once I experienced family therapy in training I became hooked ... I wanted to understand more, to know more".

Some of the respondents entered into family therapy practice as a way of enhancing their own sense of competency in practice and gaining a systemic understanding.

"Well, because I had come from (an organisation) *and there I had worked only with individuals, then I went to* (another organisation) *I was put into a situation where I had to work with families and I hadn't been trained ... so when I went to Family Life Centre I asked for family therapy ...".*

"I think dealing with issues where I felt limited in the personal perspective ... the fact is the family has such a big influence ... and obviously having children of my own and becoming a family ... you realise the complexity ... so, ja, I think individual counselling, my own life experiences, made me think that family therapy was a strong way to go ...".

One respondent's interest in family therapy came about in part as a result of her own sense of loss when her family-of -origin relocated, as the comments below suggest.

"I think some of it was curiosity, in that the year before that my parents weren't here and I had no family ... I was living by myself ... I didn't have a lot of interaction with family because I don't have any extended family ... I had a lot of feelings, impressions, ideas and stuff about the consequences of my parents leaving and how I changed as a person ... I certainly changed as an individual and not all of it was good, I know that now ... it could have influenced my decision to want to do family therapy, not necessarily to make

right … I suppose to observe that kind of interaction in a way … and maybe what I've taken out of it and what I've learned about myself, is different to what I would have if my parents were still here …".

Thus the experiences of respondents that led them into the field of family therapy range from study requirements, personal beliefs about families, experiences in their own family-of-origin and a quest for professional growth.

- **Significant influences that nurtured an interest in the field of family therapy:**

Findings on influences nurturing an interest in family therapy practice reveal the numerous paths taken by the respondents in their career history. Some similarities are in evidence, as the following comments illustrate.

"Well I think that, um, I'm sure that (team facilitator) *did … it was partly through her that I got involved … and then my own beliefs about families".*

The issue of personal beliefs about families was mentioned by another respondent, who had the following to say.

"… my own belief is that family is core to a person's health … the family should be able to affirm, discuss, help with problems, find options, support … the family should be fulfilling all those functions and if its healthy it does … so that quest for the health of a family is quite a strong drive".

"(Team facilitator) *… mm (nods) … and then when I was at* (another organisation) *and I didn't know what to do with the family … I had read about family therapy and I applied it and it didn't work … ja,* (team facilitator) *is more a natural worker, less theoretical, more spontaneous …".*

This respondent went on to state however, her opinion that Family Life Centre is weak on the theoretical component, although the experiential aspect has enormous value. The impact of working with families in other organisations was mentioned by another respondent.

"... when I was studying psychometry and I did a year of forensic practice which was pure divorce and I was dealing with clinical interviews with each parent separately and then also assessments of the kids, and then having to write reports ... and I saw it very much from the child's perspective ... maybe the adults are cruising but the kids are not ... maybe those were influences ...".

"I think my lecturer at RAU, um, really nurtured that ... when I saw it in practice like that, doing it in role-plays, seeing the benefit, the power of that, that really grabbed me ... and that's what made me come to Family Life Centre ... this was the only place I could find that does it, so that's my main reason for coming here (as an intern) *...".*

"... I remember the first time we had a module on family therapy, we spoke about how the family has symptoms ... and I just felt, gee, why are they sending this child for years of individual therapy when she's the symptom (of family dysfunction) *... I think that was quite a defining moment for me ... a light came on ...".*

"I was fascinated by the Milan school when I read about it ... it was such a radical departure ... and the complexity of working with a group of people fascinated me ... I'm not convinced we were well trained at university ... and at Family Life Centre, the influence of (team facilitators) *helped me get involved ... I began to feel confident that I could do this ...".*
This respondent stated her appreciation for the opportunity the reflecting team afforded her to bring in other ways of working with families.

"The leader of our team influenced me ... she's someone I feel comfortable with and appreciate how she deals with families ... and reading, Tom Andersen definitely influenced me ... and Michael White ... also the other members of the team".

As has been mentioned throughout a number of themes, the importance of team members and team composition is also of significance for another respondent, as the following comments intimate.

" ... I think having a good team ... a good team fosters and keeps that continuing interest in it ... you're in an environment where you feel you are always learning, you want to learn more, you're learning about yourself, about the process ... it was also nice going to the Michael White workshop, seeing how valuable it (family therapy) *can be ... its rich and interesting ... it's a fantastic learning opportunity".*

This respondent went on to say that team dynamics and personal issues with fellow team members may interfere with the experience of family therapy practice in a reflecting team situation.

"... I think if you feel like you're being supervised by someone you don't like or you feel you have to work with someone you don't like, um, you disconnect ... so you don't participate in the way that you could ... you don't feel like it's a conducive environment...".

The issue of a society that focuses on an illness/medical model approach to family health was mentioned by one respondent, who stated that this perspective *"... made me want to explore another understanding ...".*

Thus a number of significant influences that nurtured an interest in family therapy were mentioned by the respondents, including team facilitators at Family Life Centre, workshops, lecturers, and personal beliefs and experiences.

- **Aspects of self brought to the family therapy context:**

A number of aspects of the self are mentioned as significant by the respondents. As with a previous theme, the issue of the wounded healer arises, albeit in differing contexts. The reflections below illustrate.

"Feeling I can contribute because I have a sense of what it's like to be in a family that doesn't work well ...".

Conversely, for another respondent, there is a sense that her own absence of trauma in her family-of-origin means that client family issues hold no resonance for her, that pain is not evoked by their experience of pain. Her comments below testify.

"You know, its often written about, if you have experienced something you have greater empathy and you know what it feels like ... but I also feel that I come in without that baggage in a sense, where I'm not listening to my own hurt when I hear something ... I don't have the baggage, I don't have the trauma they've experienced ... so I think what I bring to the group ... um, I feel uncluttered in a sense because of my own experiences, um, yes I'm limited because of a lack of experience in some of the trauma ... I think if you've gone through any difficulty and got over it, that's sufficient, it doesn't have to be the same ... I feel I come from a place of peace".

Of interest to the researcher is the difference of opinion regarding the concept of the wounded healer. The comments of one respondent seem to bridge these opposing perspectives, and resonate for the researcher.

"My own experiences ... maybe having grown up in a family without a father ... but everything about you is part of what you bring ... and also there's difference, and maybe that's what is important ... you introduce difference, simply because you see it from your point of view which is different from theirs".

The issue of respect for client self-determination was important for a respondent, who commented thus.

"Strong values around family ... I've seen a lot of trauma with divorce, with friends as well ... so I know I've got quite strong values around that ... but ***not*** *to the point where I'll ever say to a client, you must not go that road, and if they've chosen to go that road you've got to assist them and have a very open mind ... you have your theory and own personal values but for me they must never determine the road the client has to take ...".*

"Ja, I think honesty, openness, my ability to hear, not just the words but to understand the feelings behind them, and to reflect them ... and to risk, to risk saying some things that are not often said".

"I would hope I bring my sense of respect for other people ... I hope I don't, um, come across as judging or assessing ... I would hope that I brought an openness, that people would feel like they could say something to me, whether it be a family or a team member ... that they would know that I would try and listen with the best of intentions ...".

This respondent went on to emphasise the value she places on being present and committed during the therapeutic encounter.

"... I'm also a person who is quite consistent, I don't muck around, I take things seriously ... so I would try and participate in the process as much as possible, try and give of my best at all times"

The personal values of respect and openness echo in many of the remarks made by the respondents, as can be seen above and below.

"Curiosity, openness, respect ...".

Acceptance, not knowing, not being the expert, allowing each family member a voice and validating their perspectives, are aspects of the self one of the respondents feels she brings to the family therapy context.

A further aspect mentioned by a respondent regarding what she brings to the family therapy context, is a sense of authenticity regarding self and theoretical approach. According to Spinelli and Marshall (2001:169), an approach that feels right for the therapist is more likely to be practiced in an authentic way, thus benefiting the therapeutic encounter.

The respondents bring many aspects of the self to the therapeutic encounter. Significant aspects mentioned are personal family challenges, the values of respect, self-determination and acceptance, a sense of dedication to the work and authenticity regarding theory and self.

- **Awareness of personal responses during the therapeutic encounter:**
- **Knowledge of when/when not to use personal responses to facilitate the family therapy process:**

Carr (2000:137) and Snow (2002:298) describe the work of Carl Whitaker who believes that being with the client family involves the intuitive use of self-disclosure. Andolfi and Angelo (in Haber, 1990:376) state that personal affective responses in the form of images, moods and symbols may be used to initiate and develop the therapeutic process, and that these are a constant source of information that allows the therapist to be more congruent, flexible and creative. However, this involves a risk, whereby the therapist becomes undifferentiated in the family system, loses perspective and is unable to facilitate the construction of new perspectives and solutions.

The responses of the participants regarding the above two themes were often spontaneously linked during their reflections, thus making separation of the themes cumbersome and arbitrary. Numerous similarities are evident in the responses, although some differences, particularly relating to the use of self-disclosure, are apparent.

"... it takes huge, huge self-awareness ... it's a hard job that we do ... being aware of what you believe but being aware that the client may see it differently ... personally, I don't use a lot of self-disclosure at all ... for me the boundaries are very firm ... but I think you can do a lot of damage with self-disclosure because its not about you, its about them ...".

"I'm very aware ... I maintain as much as is humanly possible a meta-perspective so I'm constantly aware of whose hooking me, why ... so I filter out my own stuff before its presented to the family ...".

This respondent went on to say however, that this awareness is still a work in progress, something she continually strives for. Regarding self-disclosure, she believes in following her instinct and intuition, and commented as follows.

"... purely going on gut ... because sometimes when it seems inappropriate I say things that work! Sometimes they don't, but often they do ...".

Another respondent listens to her inner processes to guide her as to the use of appropriate self-disclosure, as the comments below illustrate.

"(Nods) I do have it (awareness) *... because if I'm feeling something I'll know what I'm feeling, and I've developed a skill that will tell me, is this mine or does it belong to the process ... if it is, then I think to myself, is it an appropriate time to bring it in, and if I feel it is, I'll say it ... if its mine it doesn't get shared ... and timing is very important, crucial ... I'll use it for the purpose of driving the therapy forward if its appropriate to the process, and the timing is right".*

Conscious emotional responses can provide important sources of information, revealing subtle processes in the therapeutic relationship. Arons and Siegel (1995:126) believe that problems arise when emotional responses are unconscious, and that to be effective as counsellors we need to recognise and understand the source of our emotional responses. These views appear to resonate strongly with those of the respondent above, and perhaps for many others.

"I think self-disclosure is really quite valuable when its relevant, especially if its something I have worked through in my own life ... it may give the family a feeling of 'well I'm not alone in this' ... but of course, within serious limitations ... its very important to have that knowledge (self-awareness) *... you can't just use your experience and impose it on other people ... you have to use your discretion ...".*

A few respondents remarked on the choice of words, as well as the delivery of them, as the following suggest.

"... not to be impulsive in your responses ... try and consider ***how*** *you respond, and what words you use".*

"I think I am aware of, um, I think of the responsibility of saying what I say ... more ***how*** *you say it than what you say ... always ensure you are responsible for your point of view".*

"Because you're in a reflecting team you become aware of how you are with each family ... aware of the language you use ...".

For this respondent, sensitivity to the family members as well as awareness of one's own propensity to be drawn to certain people or issues is critical to the process. The significance of this issue is shared by another respondent, albeit from a different perspective.

"I think because I feel strongly about a lot of things, about particular issues, like if something happens that pushes my buttons in a way, I'm quite in tune to it ... you think and reflect on it, and you can make sense out of it ... I would say I'm fairly aware of my self ... I wouldn't say I use a lot of self-disclosure or share a lot of myself ...".

This respondent feels there are times when self-disclosure is used too freely and is unnecessary to the process.

Two respondents shared a similar perspective of self-awareness being more elusive and enigmatic, as their reflections reveal.

"I'm not always aware ... I sometimes pray before a session to find the words to connect ... and I'm not sure always where they come from ...".

On the issue of self-disclosure, this respondent believes that with experience she has found an appropriate balance, whereas in the past she *"...used to use too much, and then I used none ...".*

"I don't feel it during the therapy ... but I do feel it post-session ... I'll analyse myself and realise something ... I am aware of, um, there are things that ring a bell for me, or resonate ... even if its just an alarm bell that might not relate personally to my experience but there's a sense of alarm, or discord in something ...".

With regard to self-disclosure, the respondent shared these views.

"I used to not do it ... but now I try and use my self, I use my responses ... I love Virginia Satir because she was one of the first to advocate self as a very important factor ... systemically you are part of the group, you are in the system ... but I won't give personal information easily, um, in the sense that it creates an awareness of me ... the idea for me

to disclose is to create a greater awareness of their interaction, so I don't want to create a fascination with my life, create a distraction ... I'll use myself, my emotions as far as their interaction goes, and the focus remains with them ... it keeps me in check, it keeps me more professional if I don't go over that boundary ".

Thus to conclude, it can be deduced from the views of the respondents that the use of self-disclosure requires enormous awareness of self regarding many aspects, and that there are risks for clients that necessitate continued reflexivity on the part of the therapist.

- **Personal qualities believed to be critical to the use of self in the family therapy context:**

The theme of critical personal qualities evoked the reflection of many shared elements by the respondents, as the quotes presented below reveal. Of interest to the researcher was how emphatic and definite the respondents were in reflecting on this theme, the tentativeness and even hesitancy of earlier explorations on personal self evaporated. Shadley (1987:128) states that the self encompasses not only professional expertise, but a level of self-awareness that provides clarity regarding which parts of the self to withhold in order to preserve strength, health and integrity.

"Self-awareness ... it's critical! Knowing yourself, knowing your family-of-origin, knowing your internal objects ... because that's going to evoke certain stuff ...".

"Self-awareness firstly! And knowledge of your own family dynamics, those are vital ...".

The respondent reiterated her view that exploration of one's own family issues is essential in order to be aware of *"...where the hooks are...".*

According to Worden (1999:49), the therapist's personal experiences and issues involving their family-of-origin and life cycle stage shape the unique worldview of each therapist and impact on the capacity to form therapeutic alliances. Therapists carry with them the "…paradigm of their family-of-origin" and are thus susceptible to family

systems at work (Worden, 1999:50). Despite many shared elements which enable both client family and therapist to feel comfortable and connected, a danger could lie in a mirroring of family dynamics which may prolong a sense of being 'stuck' and make change more difficult.

"Extremely high levels of self-awareness ... a lot of insight not only into yourself but into the client ...".
This respondent also mentioned the issue of developing a *"...style of working ... you've got to find your own way ...".*

"The self is a fundamental part of the person-centred approach, so there is a lot of attention given to the self of each individual, the self of the family and of course, my self ... I must know my self, look at my family-of-origin ... so self-awareness is very, very important ... and also communication skills, building a rapport, compassion, respect, non-judgementalism".

Duhl (1987:74-75) emphases the significance of knowing the systems within the self, being aware of one's thinking and beliefs relating to the stages of life, exploring the myths, rules and stories of one's own family and others in order to become aware of how we get hooked into certain scenarios and thus become reactive.

"I think you have to be a person that assesses things well and be in tune with both yourself and the family, and the things happening around you in the session ...".
The respondent went on to emphasise the importance of self-awareness in the context of knowing how to respond to the needs of different client families, as well as regarding self-disclosure. She believes too, that *"... self-awareness develops over time ...".*

"You must have a certain amount of self-confidence ... sometimes I'll start with a new client and I know they're assessing me, whether I'm going to do or not (laughs) ... I don't think you must feel threatened ... so I think confidence is a quality you need to have. Your ability to be humble, to be able to learn (from the family) *... to admit you don't*

know all the answers ... um, honesty, and integrity ... and caring, you have to obviously have a quality of genuinely caring ... I mean I have had clients that I really didn't like, so I needed to find a place where on some level I could care, just a sense of connecting and, uh, compassion ... because you don't feel the same about every client".

Perhaps in a different context to the above, one of the other respondents mentioned the issue of *"... valuing difference ... encouraging or embracing difference ...".* There may be occasions when a therapist feels that the difference is too great, or the dislike too compelling. In the literature review (chapter 4:254), it was mentioned by Treacher (1995:205) that it is no dishonour to respectfully transfer a family to a colleague if the therapist can acknowledge his/her inability to help a particular family.

Finally, one respondent emphasised the importance of the self as a key element in a therapeutic encounter, illustrated in her comments below.
"The use of the self is a personal quality! It is in itself, the ability to use the self, because the self is the tool ... you are the tool! I think that is the magic, in therapy its very hard to pinpoint what clients get out of what you do in the room, and often what we think is what it is ,it isn't! Its something else ... its you as an individual and how you connect with them ... its communicating an acceptance, a hope ... if you are aware of self then you can communicate that, and if you are spilling over your own personal stuff, you can't ... you've got to be self-aware ...".

Satir (1987:23) sees the use of the self as integral to the therapeutic process, believing the self to be a tool for change that should be used consciously in intervention. The respondent went on to ponder on what makes an effective therapist.
"... book knowledge on its own, or theoretical knowledge, that's not it ... there's a magic that occurs, that no-one can put a finger on ...".

According to Baldwin and Satir (1987:153), therapeutic theories and techniques can never overshadow the self of the therapist.

As can be concluded from the responses above, the importance of self-awareness and the self are essential qualities of the counsellor in the therapeutic process. Also emphasised were knowledge of own family dynamics, family-of-origin issues and knowing when these may be impacting on the therapeutic encounter with the client family.

- **Discussion of the way a personal crisis was dealt with and resolved – new outcomes or conclusions that became available and contributed to family counselling career:**

As with all of the themes in this section of the interviews on personal self, this discussion was intended to be less about the actual details of a personal crisis, and more about the outcomes and conclusions that may facilitate the process of family counselling. As has been evident throughout the interviews, the openness and willingness of the respondents to share personal experiences and explore how these impact on the counselling context is deeply moving for the researcher. Once again, the tone and voice inflections shifted to a softer, more reflective stance.

As mentioned in the literature, and previously in relation to the findings, Goldberg (1986:57-58) suggests that the experience of distress and loss may result in a sensitisation to the suffering and struggles of others and of self. Some of the respondents explored issues of loss, as the following reflections testify.

"Well, my mom died and uh, I think I've resolved that ... because we were very close ... and talking about it dealing with loss, that's one way ... but when she died my brother and sister reacted differently, and that was useful ...".

The learning from this experience of loss created a very real awareness of the uniqueness of the individuals within a family, and of the idiosyncratic responses people have to the same event.

"Well, when my dad died, before I even started on this road, (family therapy) *and now I can look at that with hindsight ... I think that as you deal with crises in your own life,*

difficulties in your own life, um, you're better able to understand the clients perspective …".

The respondent went on to share a more current aspect relating to her personal life that brings new knowledge and has the potential to influence her work with some families.

" … and having kids, dealing with my little boy whose kind of borderline ADD … oh definitely, if I think about the journey I'm on with my little boy … he hasn't been diagnosed but he's quite, uh, fidgety, and he need a lot of hands on stuff, so I did a lot of research on my own, in terms of diet and whatever … so I'm able to share that with clients if appropriate, and refer them to various people … not that its resolved, its kind of an ongoing process …".

With regard to personal issues being a journey that is ongoing and still in the process of being resolved, one of the other respondents had the following to say.

"… the issue of respect between family members … I think that has impacted a lot on how I feel about families and children, the lack of respect between family members is so damaging … I probably felt that I wasn't given enough respect for who I was as a member of a family, and even with my, um, distant family there's been a bit of that … its not 100% resolved but is resolution in progress, and its much better … being able to express you feelings … without being dismissed and disregarded … I've seen so much of that in families and its something I feel should be worked on …".

"Um, I suppose the biggest one really was my divorce …. I don't know if I resolved the issues around divorce … I think what it taught me was that there's no perfect relationship in the family, and that its importance to explore every option before you make a decision … because in my case I don't know if I made the right decision, but I made it with limited knowledge of resources at the time … and I might have made a different one had I, had I been given different options, helped to explore different options…".

The outcome of this painful loss for the respondent is the awareness of facilitating a process for the client family, of considering all the options, not limiting understanding of choices and as far a possible, consequences and *"… yes, exposing to them what the broader picture looks like…".*

"I think I would have been a very different person if my family hadn't left in the way that they did, you know, if my moving out of home was a natural transition and it wasn't a situation of being forced to … being forced to be by myself and get my act together very quickly … I suppose for you to succeed in a time of crisis, when you have so little other recourses, you have to be strong …".

This experience has left the respondent with a sense of looking for the strengths in a family, as the following suggests.

"… when you're with your clients, affirm their ability to cope … often people feel they can't cope, don't realise the extent of their coping capacity, so I think it probably made me more conscious of trying to push people's strengths, not be so deficit-focused …".

The main thrust of solution-focused family therapy is its emphasis on strengths and positives, with intervention seen as a collaborative and empowering enterprise (Lee, 2003:390; Carr, 2000:133).

Other respondents focused less on experiences of loss and more on the impact of self-awareness and the capacity for reflexivity, so as to facilitate a more positive therapeutic outcome for families.

"Because I've been the rescuer in the family its very easy for me to spot the rescuer in a family (in a counselling context) *… and how addictive that role is, I can identify with that … so in therapy, to shift her* (the identified rescuer) *forced me to shift mine, in my family … you can't ask of a client what you can't do …".*

The experience for this respondent was one of recognising a familiar role being played out, both in the context of her own family, and in the therapeutic encounter. If one considers transgenerational family therapy theory, Gladding (2002:133) states that the differentiation of the therapist from her own family-of-origin is crucial, and that the family therapist may experience difficulty in working with a family whose level of differentiation is higher than her own.

Another respondent had an experience in counselling where a husband made comments to her of a sexual nature, in the presence of his wife. After an initial feeling of shock the

respondent feels she was able to separate the personal and professional aspects, as the following suggests.

"... I could actually look as his behaviour separate from me ... and it was helpful, for me this insight and the learning was about not being thrown with what people say but to try and work out what is the meaning of it, what function is has within their relationship ... in a sense, not taking the responses towards me personally ...".

Other aspects mentioned by respondents relating to this theme, are being able to empathise deeply with families as a result of resolving personal issues, but with the capacity for reflexivity in knowing when this is appropriate to the clients' process, and when not.

The personal life experiences of the respondents have clearly impacted not only on their choice of career in the helping professions, but also on the capacity for reflexivity and self-awareness, and thus in contributing to their professional development.

- **Ways family therapy practice may have affected your personal life:**

According to Viljoen (2004:23), the hazards of practice are extensively described in the literature. Four potentially problematic aspects are considered: the impact of professional relationships on personal life; the dangers of reflection; the loss of intimacy; stress and burnout (Viljoen, 2004:23- 28).

For one respondent, there has been a price to pay for therapeutic work in terms on her personal life, although not specifically family therapy. She has had certain physical health issues to contend with, which have taught her to set limits in order to conserve her own health. In addition however, she feels that family therapy practice has given her an new appreciation for her husband and children, normalising for her certain aspects of sibling rivalry and patterns of family interaction. This theme arose for many, if not most of the respondents, as an outcome of family therapeutic work. The comments below illustrate.

"I think probably in a similar way to what forensic practice did, in that it makes you aware of what you have, and you must be careful of what you have, watch out for what you have, and value what you have … and that families are work, relationships are work, and not to take things for granted".

"I think its allowed me to reflect stronger on my family interaction … yes, very often I'll be sitting with family (at a family gathering) *and I'll start observing the interactions … I've become more of a family observer …".*

Viljoen (2004:25) states that the continual reflection and monitoring of one's self and professional development may contribute to a sense of isolation. While this may not be true for this respondent, it seems that for her, as well as the respondent below, that the capacity for reflection has deepened.

"Well it has affected my personal life (laughs) … because you go somewhere and see people interact … it definitely affected me as far as observing other marriages and systems …".

The respondent above feels that the experience of family therapy practice has enhanced her own capacity for both self-analysis and analysis of family situations, crediting the reflecting team as being an important aspect of this growth process. In addition, she expressed the following comments which reflect her growth as a therapist.

"… um, family therapy has helped me not be put off emotion, and I find I handle marriage counselling better, and I handle individual counselling better because I've come to a greater acceptance of high levels of emotion, where it used to alarm me slightly before …".

"I think its given me, um, when I'm with my step-kids, its quite interesting, I look as it from a different perspective, and when I'm with my own family-of-origin, my siblings, I have a better understanding of what the patterns are, why the patterns are there, who wants to break the patterns, who doesn't … so its given me a broader picture to work from …".

"... makes you aware of how stuff can be very powerful, and can be very destructive ... makes you aware of things you would try and guard against in your own family in terms of the way parents treat each other, treat particular children ... the way people try and solve problems ... you have a conscious awareness of identifying your own destructive behaviour ...".

One respondent feels that family therapy practice has not impacted on her personal life, as the following testifies.
"No, I don't think so ... but professionally, yes".

In addition, a few respondents stated that their responses to the previous theme reflected what they felt in relation to the issue of impact of family therapy practice on their personal lives.

As can be concluded from some of the responses directly above, the respondents feel that family work has provided new insights into therapeutic work on a more general level, as well as enhancing the depth of understanding both personally and professionally.

- **Further comments:**

Most respondents felt that they had fully explored the topic of the personal self and had nothing further to add. One respondent added her thoughts that family therapy practice has helped her to realise that in her work with children, it is often family issues that come into play, and stated her belief that *"... family therapy is never **not** applicable, in any therapeutic environment".*

5.4.4.2 Professional self

- **Describe your career story (i.e. personal experiences that contributed to the decision to be a family therapy practitioner, resolution and outcome that may have shaped your counselling career):**

White (1990:88) suggests that counsellors come to family therapy with a story that he refers to as a "…counselling career…" which has a significant effect on the course of

training and hence, practice. Sharing the view of White, Street (1994:159) believes we come to the profession with a story that led us to helping others and that we need to address the issues and processes of our stories that may prevent our being authentic in our interactions with clients. Some of the respondents felt that much of the information relevant to this theme has already been dealt with in previous explorations. Of those who chose to add information regarding their career story, certain similarities, as well as differences, are apparent.

"I think coming from such a strongly dysfunctional family, um, influenced me wanting knowledge of understanding ... to gain understanding of why things happen the way they do ... I think each situation I come across, like the divorce, my mother dying, having an unsettling period between my divorce and meeting my present husband, um, sort of gave me an exposure to issues and problems in life that made me, ***forced*** *me to look for other resolutions or better ways, or better skills for dealing with things ... and I think the mastery of those skills gave me the desire to want to be able to help somebody else find a solution for themselves ... not give them an answer but help them find skills that would work for them".*

Goldberg (1986:60) proposes that the struggle with suffering is a universal human condition and that denial of one's own suffering poses a problem for the client in his/her own personal journey of suffering. Personal struggle is necessary for the practitioner's growth as a therapist, and serves as a resource for the client (Goldberg, 1986:61).

"There was this offer made at the beginning of the intern year, there was an option to join the reflecting team ... so it wasn't like it was something I'd heard of and wanted to do, you know, given a lot of thought to ... I realised it would be very good experience ... everybody comes from a family ... I had a bit of a dysfunctional family and I think that the dynamics within a family always contribute to relationship difficulties and in my personal experience that's exactly what happened ... so it just made sense to get involved"

.

As can be seen, the respondents above identify their own family struggles as part of the journey into the family therapy arena. According to Sussman (1995:24), an appreciation of how practice facilitates personal growth is gained by allowing us to use the best of ourselves while providing opportunities to face and accept our shadow sides.

The issue of family therapy being an opportunity provided by Family Life Centre was mentioned by another respondent, as well as her additional studies which required work in family intervention. The theme of a desire for professional growth emerges in various ways in some of the respondents explorations. The realisation that one is never fully 'trained' or all-knowing allows a fundamental creativity, and according to Lantz (1993:38), the therapist's own willingness to change may be a vital asset in helping others.

"My lack of experience, that was really it ... my lack of experience in family therapy ... I knew I was missing, um, there's a complexity in the individual that I need to know, that's not the whole story ... because I wanted to be able to work with the whole story ... if you are truly working with the system, then you've got to work with all the components".

"We have mentioned this but I think that there is now, a continuous family perspective, maybe because I put so much value on family ... and I almost feel that if you don't resolve family issues they go on and perpetuate ... and almost for the whole family's mental and emotional health, its so important that they have a healthy family life ... that's a strong feeling, I think that is a prescribing feeling for me, as far as doing family therapy".

"Again, it wasn't anything I was necessarily aware of up front, um, because it was part of my studies ... but when I kind of knew that psychology was in fact the road I was going to follow, that one of the areas I would like to work in was families ... but no, I can't say that anything specifically led me in this direction ... I think because I have strong family values ... strong Christian values as well ... they definitely do guide the choices I make ...

so I suppose it wasn't really fate or chance … maybe there's a higher hand at work here …".

For one respondent the influence of wider social systems on herself and her career choice is illustrated in her discussion.

"I grew up in a family that was very aware of social issues and stuff like that … like my mom started the first black inner city school at the time of the Soweto riots … I had an acute awareness of discrimination and injustice … we had a bomb put in our letter box when I was ten years old … so I had an awareness of that kind of thing at a socio-political level, and that made me want to do social work … I think sometimes there's a danger that people choose to live by ignoring the broader environment, every problem is located in a context and you have to be aware of that context, whether it be political, social, economic or whatever … having that awareness because of my past, that influences … and my family-of-origin probably influences my attitudes to family therapy and my work with families … ja".

White (1990:88-89) suggests that the retelling or re-authoring of the career story has positive effects on counsellors work and life in general. It is the hope of the researcher that this is how such retelling is experienced by the respondents. The career stories of the respondents are varied and fascinating, illustrating their challenges and the diverse paths taken. Of interest to the researcher, was the fact that in the weeks after the qualitative interviews had taken place, many of the respondents spontaneously mentioned how much they had enjoyed doing the interviews, and how it had made them contemplate their stories.

- **Preferred ways of being as a person and as a family therapy practitioner:**
- **Experience of fit between preferred ways of being as a person and as a family therapy practitioner:**

Lantz (1993:37) states that effective Franklian intervention requires a commitment to authentic communication, and that the role of the therapist cannot be "…divested of its essential humanness". This view is shared by Satir (in Baldwin M, 1987:10) who

believes that healing which can only be achieved through the "…meeting of the deepest self of the therapist with the deepest self of the client". As with some of the other themes already discussed, the reflections on preferred ways of being and experience of fit were often combined spontaneously by the respondents, and are thus explored together.

"Its to be available, to be holding, to give them a sense of hope … not my hope but theirs … to create a context which is a relationship where they can be heard … ja, there's a big fit … absolutely, because I think at the core it fits with me, its what's fulfilling for me, as an individual and as a professional … they don't necessarily overlap but there are a lot of overlaps … I think being vulnerable, not being perfect, not having the answers but just being available …".

"I think as someone who can be as real possible, while demonstrating respect to your clients … ja, I think being as authentic as possible, being available, being consistent and being open and approachable … and maintaining your own boundaries … ja, I think its quite congruent … sometimes I wish I had more theoretical insight into family therapy, once you get into it you realise how complicated it is … there's so much going on…".
For the researcher, the comments above suggest perhaps, that the respondent would feel a sense of enhanced congruency if her theoretical knowledge was greater, thus making the self and the intervention a more unified whole.

"I try and be as natural as possible … I'll try and speak less than I normally speak (laughs) in the sense of, um, facilitating … I try to be as relaxed as I can be, obviously stress is important because it hones your ability to function on a professional level, but I need to be at peace with who I am and where I'm at … in a way I use myself as a tool, a conduit …"
With regard to authenticity of fit the respondent commented as follows.
"… they are very similar, pretty much the same … I think that individually, in my friendships, in my family, things like that I don't have the licence I have as a family therapist … even when my friends share things I don't have liberties to probe or to challenge …".

The difference for this respondent is the fact that if a family requests professional intervention it is within the mandate of the therapist to provide that, whereas in a personal capacity one must guard against intrusive observation or comments, no matter how insightful.

"I think I've touched on that, but whew! A lot of empathy and high levels of self-awareness ... I don't see myself as better than them (the family) *or that I have the solutions to their problems in my head ... I think we have to figure it out together ...".*

"Authentic ... spontaneous ... utilising my intuition ...".
This respondent shared her belief in the importance of the spiritual dimension, which is important in both her personal and professional life, and which serves as a guide for her. A difficulty for this respondent however, is the feeling of not being able to be authentic specifically in the reflecting team feedback *"... and that's uncomfortable for me".* The perspective of this respondent is that while the primary therapist may use a theory that fits with the self, the team reflections follow Tom Andersen's approach and these, for her, may lack challenge at times.

"Forthright and honest! (Laughs) I think honesty is high on my list of criteria and that's both personally and professionally ... having respect for your clients and confidentiality, and your friends and family, is vital for me, that when people share, they share from their heart and its important to respect it and hold it in that place ... I believe if you don't have a strong ethical standpoint in your work then I don't believe you have the right to, um, do it ... ja, my values are basic and simple but they are the same in everything ... I believe in walking the talk ...".

For one respondent, the experience of authenticity came as a result of her postmodern perspective, which is congruent with her sense of self and her experiences in her own life where the recent acquisition of two daughters-in law brings difference into her family.
"It's a good fit ... embracing difference and multiple perspectives ... it's very interesting to sit and observe the family ... you become aware of the differences ...".

Figley and Nelson (in Hanna & Brown, 1999:82) explore therapist flexibility. Being respectful of difference and understanding that one reality does not work for everyone are characteristics of a family therapist who has learned to be flexible. The constructivist position is central to the view that reality is subjective and individualistic.

"Um, I'm not sure ... I do think that who I am is who I am, and I more or less interact with people in a therapy session in a very similar way as I do in general day-to-day life interactions ... perhaps I'm a bit more serious and I'm a better listener ... generally I would say who I am in there, is who I am ... I don't feel like I'm changing hats, maybe adjusting the hat a little bit, adding or subtracting some or other bow or decoration to the hat (laughs) ... but ja, they're not completely different hats".

The issue of being similar in both the personal and professional contexts was also mentioned by one of the other respondents.
"... I don't think I'm necessarily that much different when I'm sitting with a client than I am when sitting with a friend ... obviously in terms of the content of the conversation yes, but in terms of my demeanour ... I think there needs to be congruence ... maybe I'm more aware of the boundaries when I'm with a client but no, I don't feel as if I'm playing a role".

As can be seen from the comments above, the respondents believe in the congruency of their preferred ways of being, both personally and professionally, and that this congruency runs like a thread through their lives on all levels. Some difficulties are apparent however, and it seems that at times the reflecting team context may hamper the sense of professional authenticity in family therapy intervention.

- **Hopes about how families experience themselves when with you:**

Many of the responses illuminate the wish of the therapist for the session to be a safe space for the client family to explore, and that the process will prove facilitative of change, as the following indicate.

"I would like for families to um, feel safe, to feel a sense of honesty and confidentiality, a sense of professional interaction ... to feel enabled to drop the defences which block growth and honesty between themselves".

"Well, I hope their experience is that they're OK ... that they haven't done something wrong and terrible".

"Comfortable, relaxed, open, trusting ... recognising the need for change and having the courage to change ...".

One respondent believes that family therapy can be a difficult experience, especially at first, and her hope is that by being her self, they are enabled to be themselves, suggesting the importance of congruency for this respondent.

"My hope is that they know that they have the strength to get through this and that they have the abilities, or the skills, they just haven't discovered them ... and that there are better ways of being and more constructive ways of being than they perhaps are experiencing at this time ...".

"That's a major impetus for me ... the sense of regaining self-worth ... definitely hope to change ... to validate the strength of emotion, there's a sense that they lose respect for themselves, um, devalue themselves and I feel to regain your self-respect and the way that I treat people, I think I'm doing it the right way ... they can regain a sense of pride ... feel empowered and strengthened in the process ...".

"Well, one hopes it will be a comfortable place for them to be, and that's one of the things that jars for me, um, that window thing ... it isn't always comfortable ... it might take a little bit more time to get the bonding going and get to a point where everyone feels comfortable , so they all feel they have a voice ... that what they say is heard ... that you make it possible for them to express to each other what they need to say, help them find some kind of a way to move forward".

As can be deduced from the above comments, the respondent feels ill at ease with the one-way mirror, and believes that it may inhibit, at least initially, the ability of the family to relax, thus impacting on the development of a therapeutic alliance with the primary therapist.

Thus, creating a safe therapeutic environment and facilitating the change process are hopes respondents have for the client family.

- **Awareness of professional role during a therapeutic encounter with a client family:**

Zeddies (1999:231) states that the relationship between a therapist's personal and professional identity is continuous, reflecting a dynamic relationship between what is meaningful or significant on a personal level and the theoretical/technical aspects that are learned and practiced. Developing a therapeutic style that is both personal and professional is a central developmental task. Awareness regarding the professional role during a therapy session with a family revealed a mixture of responses, as the following reflections illustrate.

"From that point of view I know that I am a professional in terms of my theoretical knowledge but I'm not the professional in terms of their family ... they have better knowledge and understanding of their own family ... I don't profess to know why they do things or tell them how they should be different ... I rather allow them the opportunity to find ways that might be constructive to them ... so I try not to take a role of authority ... I just try and take a role of facilitator".

The respondent below echoed very similar themes.

"Well, in my head I've got the theory and the skills but I'm not there to impose those on them ... I'm there to figure out with them what's the best way to move forward ... I'm not the expert, I don't see myself as the expert, rather a facilitator, mediator".

Some of the other respondents believe their professional role is more to the forefront of their thinking, while a few suggest that it takes on less significance during the actual therapeutic encounter. That is not to imply however, that professional aspects are forgotten. The comments below elucidate.

"I'm very aware of that, confidentiality, the manner in which I do things, the responses I give, the way I direct it ... I've got to give excellence, they can't come and just waste sessions, I've got to give them value, so that is very much paramount".

"I don't think you can lose that awareness, I don't know that we can just see ourselves as having a chat or having, you know ... ja, its not possible to be there with a family and not be (professional) *... that's why you're there".*

"I think that when I'm with the family , my role is part of that family, and that my being there is going to shift the dynamics of the family ... so that my being there is going to be a variable that shifts the dynamic of the family ... so I'm very aware of my role as influencing the family dynamic".

"I'm fairly aware of it but not to the point where it takes the humanness out of me and I become cold and professional and clinical, not to that extent ... but yes, I am aware of the ethical, professional side that has to be between therapist and client ... I am aware of that, I'm part of a professional team ...".

"I'm probably, um, I come across as quite professional ... I'm quite aware of what I'm meant to be doing, I'm not there to have a random conversation about interesting things ... so I'm quite conscious of what we should be doing ...".

This respondent feels however, that there are times when it can prove difficult to maintain the focus fully on the client family, which puts one at risk of becoming unprofessional.

Two respondents shared a similar view regarding their professional role, that in really being with the family, the professional role becomes less prominent, as reflected in one of their statements below.

"You know, I actually just forget about it … I suppose it is part of your professional role but one becomes so aware really, of trying to listen to the family, to understand them, that they become the focus rather than your role".

In conclusion, awareness of professional role is viewed as an important aspect of the therapeutic encounter, the difference in responses centring on whether or not it is more in the foreground of the therapist's perception.

- **Beliefs about the impact of your professional role on the client family:**

Amundson *et al.* (1993:111-112) refer to the twin temptations of power and certainty, and refer to "…colonization…in therapy" where a commitment to expert knowledge blinds us to the experience of the family and fosters a "…colonial discourse". Gilbert *et al.* (1989:8) suggest that the more insecure the therapist, the more likely he/she is to hide behind the use of technique, without listening and exploring with the family. Technique can hinder the development and process of the therapeutic relationship, removing the person of the therapist. The personal characteristics of the therapist determine how a particular intervention is presented to the family. An aspect raised by many of the respondents in contemplation of this theme, is the issue of client's expectations regarding the role of the professional. The comments that follow illuminate.

"I think a lot of families, people, clients, come to you thinking that you are the expert and they come wanting you to give them a prescription of how they must go away and behave, and usually when you don't do it, those are the families who don't continue with the process … they come with their own agenda and you don't meet that agenda, so they move on, yes, they move on to find someone who will …".

"Well, I think they have this weird idea that you might be the expert … that's obviously going to have an effect on them, because they're going to be on their best behaviour …

and I think that's why it takes a bit of time to build a relationship … to feel they can be real … I think that's where children can help (laughs) … they're less defended".

"Sometimes some clients expect you to be the expert … and they're disappointed when you're not …".

"I think it probably depends on the family … and also depends on the belief or attitude of different people towards a therapy session … if you have some people who want it to work and others who see no value in it, then it becomes difficult … its much easier when people have a mutual understanding (of the process)*".*

"… my professional role is as a healer and I'm hoping that the impact of the that on the family is that they realise I'm here to heal and not to judge … although I don't think we can be naïve about being judgemental because we're always in a judging role … so its to know that what I'm doing is in the interests of healing, not in the interests of my position, my expertise …".

This respondent also emphasised awareness on the part of the therapist regarding the issue of judging, and that a lack of awareness is more dangerous to the power dynamics than acknowledging it as part of the reality of being human.

According to Satir (1987:20), power has "…two faces…", one controlling, the other empowering, and the use of power is a function of the self of the therapist, related to self-worth. A lack of therapist awareness regarding choice of an approach and a fit that coheres with the values and beliefs of the self, and unawareness of own ego needs may result in denying, distorting or projecting needs.

One of the respondents' emphasised the element of stigma that persists with regard to therapeutic intervention, as the following comments describe.

"… there's still this view in society that if you're seeing a therapist or a counsellor then it means there's something wrong with you and people want to avoid that … but maybe you can reframe it for them …".

The respondent mentioned too, the issue of clients expecting expertise and to be 'fixed', an aspect that also requires reframing.
"... but I like to let people see that there's another way of looking at it, they'll be more open to taking ownership ...".

The issue of ethics with regard to client's perception of the professional role was mentioned by a respondent, who had the following to say.
"It's a huge impact, professionally I mean, there's codes of conduct and they are there for a reason, to protect the client first of all, but also to protect the profession ... this is about how I conduct myself with integrity ... I need to know that I did it to a standard that I find acceptable".

The reflections of one respondent indicate a feeling of satisfaction that her professional role impacts positively on the families she has dealt with thus far, while for another, her lack of experience makes it difficult to assess.

"Well, all I can say is its working up to now ... so it must be working for them ... I think because I remain congruent in the way that I am and that I don't take sides, um, I try to share the load with everybody and be as honest as possible ... its containing for the family".

"Its difficult for me to say because I've only really seen one, um, dealt with one family and um, the rest of the families, I've been part of the team ... but even as part of the team one makes comments, so, um, I don't know what peoples' expectations are in family therapy ... hopefully the impact is that you are a professional ... the organisation involved is also very important, you know, Family Life Centre is a very well-reputed professional organisation, so clients would expect professional, um, because of the reputation".

Creating a therapeutic encounter that facilitates the co-negotiation of solutions requires dialogue, curiosity and empowerment, rather than certainty and power (Amundson, *et al.*,

1993:117). Rather than seeing the therapeutic encounter as aimed at attaining certainty and security, it is more a recognition of the uncertainty that is part of living, and an opportunity to explore options that may enhance quality of life. The difficulty at times, for the respondents, are the expectations of client families which may impact on how the professional role is experienced and implemented.

- **Awareness of client issues that challenge you or contribute to feelings of discomfort:**

McGoldrick and Carter (2005:28) believe the most challenging aspect of the development of the self to be one's beliefs about, and interactions with people who are different from ourselves. Baldwin M (1987:7) concurs, stating that ideas about the self are connected with our emotions and belief systems rather than our intellect, and thus we react strongly to views which differ from our own. Responses to this theme showed variation, with some respondents stating specifically the issues that would prove challenging to them, and others being less certain, either through a lack of experience or the belief that they are able to work with most client populations encountered thus far. In the latter category, the comments are as follows.

"Again, that relates back to self-awareness so that if a client is struggling with something that maybe I've struggled with, that resonates with me, and to be very mindful of keeping my stuff separate from theirs ... but I can't say that I've encountered up to now, I don't think I've got something I particularly, um ... maybe I need to experience it but no, there's no issues that I think will gob-smack me ... I don't think so".

"Um, I suppose where it really goes against my values ...".

The respondent went on to state however, that she has come to both tolerate and appreciate difference.

"I can't say I've had a lot of stuff where I've been the family therapist with the family and I've had a lot of, um, issues that have made me uncomfortable ... because I consider

myself fairly congruent in terms of my personal and professional self, if I feel uncomfortable or something is triggering me, I'm fairly aware of what's going on".

For the respondents who were more convinced of their position regarding challenging issues, the following aspects were mentioned.

"I think that the issue of addiction is obviously huge for me ... its something I can understand intellectually but still hooks me emotionally, and I have to be aware of it, um all the time ... I think being the product of an alcoholic home I would struggle with counselling an alcoholic ... though if they're coming for help maybe they want to change, so that might be positive ... but because addiction is such a, is a disease of denial, the addict often doesn't understand the impact on the family ... so I find that very hard".

Substance abuse was also mentioned by another respondent as a challenging area to work with, as is paedophilia. The respondent feels that she would be able to work with such client populations but would not hesitate to refer out if she believed an attitude on her part hampered the process for the client family. As previously mentioned by Treacher (1995:205) it may be necessary on occasion, to refer a client family to another practitioner.

"I find it quite uncomfortable to listen to parents, um, criticising and uh, running their children down ... and also when the couple begin to discuss issues where the children shouldn't be privy to ... that always gives me a bit of a palpitation ...".

The issue of patriarchy and male dominance was mentioned by one respondent, as well as *"... passivity challenges me ... people just not attempting change ... where they maintain the counselling purely to maintain stability, its like a pressure release valve ... they don't actually do the process ... that is something that challenges me".*

In a similar vein to the above, two other respondents described challenges for practice as follows.

"Resistance … um, fear rather than resistance, fear of change … if they can't self-reflect, they don't have their own observing ego or they're not prepared to develop their own observing ego … where they sit back … that's very frustrating".

"Um I think if you have one parent in the family setting who is extremely resistant to being there … it (a particular family therapy encounter) *made me feel like I was on show, like, what are you going to bring, what are you going to do for us … maybe its their attempt to end the whole process, to manage or avoid their own anxiety …".*
The respondent feels, with some wisdom from hindsight, that her own anxiety may have contributed to the experience for all concerned, and that with experience she would have brought up the issue for exploration sooner in the process.

According to Amundson *et al.* (1993:113), clients who are disposed to insights or are sufficiently malleable are viewed as the ideal therapeutic population – these clients embrace the worldview of the therapist, persist with therapy, and make progress or get better. Other clients have problems which persist - they fail to 'understand' what the therapist says, and have a tenacious hold on their own view of the issue, on personal knowledge. Such clients are viewed as 'resistant'.

While some of the respondents feel able to work with most client populations, others were specific with regard to the issues that would prove very challenging to them.

- **Further comments:**

Two respondents chose to elaborate on the themes discussed relating to the personal and professional self. As previously mentioned in the findings, Zeddies (1999:231) states that the relationship between a therapist's personal and professional identity is continuous, reflecting the relationship between what is meaningful or significant on a personal level and the theoretical/technical aspects that are learned and practiced.

"I think your professional and personal self have to be the same … you behave differently in different scenarios but you need to have a congruency between the two … at the end of

the day its your integrity in how you behave and how true you are to yourself ... and if I feel that I got into a situation where I'm, uh, I will terminate or refer if I feel there's a client that I'm not aiding or I'm not behaving or can't trust myself to behave professionally".

"Well, it must be borne in mind that I'm new at this, (laughs) so maybe I've still got a lot idealism that's going to be knocked out of me when I get into private practice (laughs) ... but that's how I see it now ... speak to me in two years time, it may be different!".

According to Sussman (1994:24), no therapist enters the profession free of illusion, and a "…mature sense of disillusionment … necessary for our full professional development, can only come within the context of accumulated clinical experience".

The development of the personal and professional is an interrelated process demanding awareness of the many aspects that combine to form the self.

5.4.4.3 Burnout

Berger (1995:303) explores the topic of sustaining the professional self over the career span, stating that little has been researched regarding this issue until recently. Of the studies that are available, there are certain identified consequences of the toll taken by therapeutic work.

- **Level of satisfaction (or not) with work as a family therapist at Family Life Centre:**

Most of the respondents indicated a high level of satisfaction with their work in the family therapy field, as the comments below suggest.

"Very satisfying ... I enjoy it very much".

"I enjoy it ... I don't think I've ever got to the point of burnout".

" ... its one of the most satisfying parts ... I enjoy it much more than working with couples ... it's a much richer, denser process ... there's so much more opportunity for change, for learning ...".

The respondent went on to state that the reflecting team members contribute to, and enhance the learning opportunity.

"A high level of satisfaction ... I think because you can see all of them (family members) *shift and change ... its not just working one-on-one where you don't understand what's happening at home and what the impact is at home ... you can see it happening there, and you can see it moving ... and that gives a high level of satisfaction".*

"Very satisfied, I love it! I love the dynamics, yes I get down by the emotions and I get incredibly drained in the process but I love the stimulation, the mental stimulation ... so it appeals on lots of levels ... I love the idea of being, um, the fact that I'm contributing to something that's getting better, that I'm part of a process that is bringing health ... so that's very gratifying ...".

"Well, I find it very satisfying ... because its so dynamic, every family is so different, although there can be similar issues ... I find it satisfying because I learn so much, the input is always great and I think peoples stories are always so interesting ... it can also be tedious at times because the same issues arise (in a family therapy session) *and its difficult to get beyond them sometimes ... so it can be pretty frustrating at times".*

"Well, lets give it a level ... I'd say I'm sitting at a 6 now, um 6 or 7 ... if I'm presented with a family or a problem that I feel would be perfect to be dealt with at a family level, then I think its such an effective way of working, with families and relationships ...".

A few of the respondents were more ambivalent about the level of satisfaction in their work as a family therapist. The comments of the respondent below relate to an experience within a particular reflecting team.

"... Fair ... I loved the process but that reflecting team drove me insane ... if it was handled differently I think it's so useful... to be able to be authentic and honest in the feedback, not to skirt and scout around the issues".

One respondent describes her level of satisfaction as fairly low, stating that it is *"... not one of the most pleasurable experiences ... there are times when I just feel uncomfortable with the way it's done".*

It can be concluded from the comments above, that while working in the family therapy arena is very rewarding, there are some aspects that are less so, specifically the issue of the process becoming 'stuck', and aspects relating to authenticity and fit.

- **Level of satisfaction (or not) with your personal life:**

Most of the respondents indicated that they were satisfied with their personal life. Of the few who mentioned some less satisfactory elements, there is a sense of being able to keep separate to some extent, the personal and the professional. Also evident however, is the link between the two aspects, and that they are interconnected with life satisfaction in general.

One respondent stated that part of her level of satisfaction related to being both financially and emotionally stable in her own life, which enables her to be in a comfortable space, personally and professionally. Personal and professional satisfaction are reflected in the statement of another respondent.

"I'm content with where I am in life".

"That's very high too ... the only limiting factor is time ... having to manage my different roles ... my dominant role is not my professional role ... my dominant role is my wife and mother role (laughs) ...".

The respondent went on to stress the importance of balancing her personal life and professional role.

"I think, ja, because I'm in a career I want to be in, I have a high level of satisfaction, and even if things aren't always working at home, this works for me … being able to master something in my life this important gives me a high level of satisfaction".

"Fine … if I am having problems (personal) *those can affect the way you relate to things but generally I try to keep the two separate".*

"Pretty satisfied".

"Ja, my personal life is, touch wood, OK … it hasn't always been but at present it is (laughs)".

"My work is my life so I'm very satisfied … but work is also my defence …".
The respondent explored how her awareness of the significance of work, and perhaps how consuming it can become for her, has resulted in her re-entering personal therapy.

Thus, personal satisfaction for most respondents is high, and for those who experience it as less so on occasion, being able to separate the personal and professional is paramount.

- **How you sustain yourself in your career as a family therapy practitioner:**

Storr (in Karter, 2002:52-54) states that it is essential for the therapist to find some area of self-expression to ameliorate the sense of becoming a non-person through living vicariously through one's clients. Maintaining a life outside of the therapeutic world is vital to minimise stress and burnout. While the focus of the theme is family therapy practice, the aspects explored by the some of the respondents relate to therapeutic practice in a more general sense.

"Self-management … I don't take too many clients … and I give myself breaks …".
This respondent believes high self-awareness allows her to be aware of her needs and she feels knowledgeable in knowing how to nurture the self.

"I think its being mindful that I need to give myself time after intense therapy ... and also to teach my family not to expect too much (laughs) ... I'm brain dead after family therapy (laughs) ... I do need to debrief on a certain level ... I need to sit down and process it, and a lot of it happens when I'm doing my report writing ... I work through the different things and analyse ... and exercise, I'm not a mad sportswoman, I just need to do something, uh, outside ...".

"... probably because I'm not full time I don't really have that issue to face ... my intern year was hard, it was incredibly hard because I had two small kids and it was long hours and it was a tough year ... then I needed to sustain myself, but I did it by you know, having time for coffee with friends, going to movies, just taking time out ... but where I am now I'm doing minimal work ... so I'm not needing to sustain, in fact if anything it's in the opposite direction (laughs)".

"Walking the dogs, visiting with friends, movies, lunch, all the usual things (laughs) ... I don't go to the gym and pound it out (laughs)".

"Well, I meditate every day, I do transcendental meditation ... if I've had a bad day I pamper myself, having a long bath, relaxing, reading junk novels ... and doing fun things for me ... I believe its important to be, as much as possible, present with my clients ... and um, I need to be healthy and whole myself ... so I'm quite vigilant about looking after myself".

Meditation was an aspect mentioned by one other respondent, together with music, art, massage and personal therapy. In addition, the issue of not taking on too many clients arose, with this resident believing that *"... the emotional demands are great ..."* and that the importance of self-care cannot be underestimated.

" ... because of the fact that we alternate (in being the primary therapist with a client family) *means that you're not constantly, um, because being a therapist is draining ... and so um, shopping, reading, movies".*

The respondent went on to add however, that *" ... there was one point in my career where I felt like I was burnt-out, or I was burning out ... and I think the experience forced me to change the way I worked, not only at a therapeutic level but in terms of what I became involved in, particularly in the community ... it wasn't about not coping but I was tired and had had enough".*
Self-awareness allowed the respondent to recognise the potential for burnout, and thus to make the necessary lifestyle changes.

"I can understand how one um, can burnout ... I mean sometimes after a particularly heavy family session you feel quite depleted for a while ... and you recover yourself and your energy by talking about it between the therapists, which is always a great thing ... ja, the debriefing afterwards always assists to, uh, debrief the whole thing ... I just feel that, um, without that and other kinds of ways of managing the stress , that it would be very easy to burn out ... personally, um I think what I do is have a cappuccino (laughs), but really just to do normal day-to-day stuff that I enjoy ... going back to one's own family and looking at them with a different light ... savouring the good stuff, it really anchors you, it gives you a feeling of contentment ... holidays, weekends away, quality time, all that stuff ... balance is always good".

One respondent mentioned sustaining aspects for herself as being ongoing learning, as well as the importance of supervision, both within and outside of Family Life Centre.

It is evident from the issues mentioned above that family therapy practice, while rewarding, can also be experienced as a demanding and even draining process. The fact that the respondents seem to be very aware of this, and thus the risks involved, suggest that burnout prevention is part of everyday life.

- **Challenges to your ability to sustain yourself:**

A number of challenges present themselves to the respondents in their efforts to sustain themselves.

One respondent believes that a challenge in family therapy practice could occur if difficulties experienced by a client family resonated with the personal experiences of the therapist. Her feeling is that this has the potential to impact on the way one practices family therapy. Satir (1987:21) suggests that in family therapy it is likely that at some point, the therapist will experience a scenario similar to his/her own family-of-origin. Difficulties not yet resolved will impact on the therapy.

"Ja, there are challenges sustaining yourself ... I can become quite anxious and feel possibly, inadequate to keep it (the process) *going ... I need to work on that ...".*

"I think sometimes no matter how much you're in touch with yourself, sometimes you're not always in tune with, um, the extent of ... I don't always know exactly where I am and sometimes, you try and just keep yourself going and then eventually you're exhausted"

"My husband, ja, he's very demanding, he's an only child and he finds it very difficult to share me ... he's quite a drain on me emotionally ...".
The challenge for this respondent is balancing the needs of her relationship with her own need for separateness and alone time on occasion.

"Yes, the other roles in my life ... other demands and other stresses, personal life stressors ... um, the fact that my therapy (her private practice) *has to pay, so it's not only a love but it's a business ...".*
The issue of additional private practice work was raised by another respondent, who raised similar themes and issues to the respondent above.

"Taking on a new role (private practice) *... the financial responsibilities and debts of setting up practice ... I feel I'm not in a position to turn clients down ... trying to maintain equilibrium between the therapist versus the business role ...".*
The importance of balancing work and personal life was stressed by the respondent.

"Yes, my addiction to work … I don't know if I experienced it in full force, where I wasn't working well … but I did experience times where I felt I was developing empathic failure … I felt exhausted, dead".

For this respondent the challenge in sustaining herself is her own sense of being driven and work-focused. She has taken time off, gone for personal therapy, and tried to achieve more balance in life, in order to prevent further experience of burnout.

Empathy makes considerable demands on the person of the counsellor, and Viljoen (2004:30) describes consequences such as empathy contagion, empathy fatigue and empathy depletion which link to the issue of burnout. Grosch and Olsen (1995:275) state that working long hours may be revered in certain professions, eliciting a sense of pride and importance, but with the price being an increased potential for burnout.

"Guilt, at the cost … it (self-care) *feels like an indulgence …".*

While the respondent understands the necessity of taking care of the self, there are times when she questions the cost.

One respondent feels that at this point in her life, there are no challenges to her ability to sustain herself.

While the respondents may not have experienced burnout in full force, there is an awareness of the fact that it can occur, that aspects of their lives may challenge their ability to sustain the self, with a potential cost to the self and hence authentic practice. Awareness of the importance of the need for self-care is high.

- **Further comments:**

A few of the respondents added to their exploration of the theme of burnout, as the comments below describe.

"I worry when … I don't know how it works when you have more and more clients … I have a small caseload, what happens when you have a bigger caseload, how do you

manage that ... I'm hoping that its going to increase at a pace I can grow at ... I'm a bit concerned that a lot of the areas of my life have counselling components, very few of them are completely recreational, which could lead to burnout ... um, we're involved in church leadership, even in my social life, some of them are people I need to walk along with or support through a time ... so it gets difficult ...".

"I haven't experienced it in this sphere ... but I did nursing before and I did experience burnout there and I know that if you don't nip burnout in the bud before it happens, or at least early, um, you can be so put off the profession that you actually don't want to go back again ... I'm sure the same applies in any of the helping, uh (professions) *... so its important to prevent it".*

"I do try to keep in contact with my creative side as well, I do a lot of creative things, because I feel that its important to keep both, you know, the right and the left brain active, so I use that as relaxation as well ...".

"Self-awareness and self-management ...".
Of significance for this respondent is feeling at peace with accepting the business and financial side of private practice as the outcome of her years of study.

"Just to be avoided at all costs".

The respondents are thus aware of the potential for burnout and the need for prevention.

5.4.5 Opinions of Family Therapy Practitioners on the Future

The themes explored below focus on the opinions of family therapy practitioners regarding the future.

- **Hopes for the future of family therapy:**

Many of the respondents shared similar views regarding the future of family therapy, with a significant theme being the need for wider availability, and a drawback relating to the expense in terms of human resources and cost. The comments below illustrate.

"I would hope that it became more accessible to more people … most organisations don't have it, and it seems to be almost a kind of elitist thing … so it would be a hope, that more people in the profession would focus on it".

"That it would be more widely used … that more therapists consider it as an alternative … it takes effort to arrange, it's a lot easier to get one person, rather than a whole family … and if its not possible for an individual therapist, refer to a place that does do it … we need a more systemic understanding, to become more aware and see it as an option …".
The importance of a systems perspective in family therapy, as opposed to individual therapy with the 'symptom bearer' were themes also explored by another respondent.

"Well, that more professionals would be prepared to give up time to be in reflecting teams … because I think in the private sector its hugely expensive and I think that if therapists would be prepared to give up time to part of a reflecting team it would make it much more accessible, and that much more powerful … and to get more exposure on what, you know, on the benefits of coming as a family for therapy, rather than just the individual …".

"I hope that it would be a growing thing, and practiced in a lot more places … I think its very sad that there's only one place in Johannesburg, with all the families … I know its expensive but you know, its needed".

The issue of the future of families in society was of concern to some of the respondents, as their reflections describe.

"I think there's an incredible need out there ... so many families out there are in crisis, I mean, divorce is destroying the family unit as we know it ... so I would say the family is in crisis ... one hopes that work will be done that will assist them ... and I'd like to have a role in that, I do see myself working with families".

"I think its got a lot of merit ... its got huge impact ... in our society the definition of the family is changing ... there are a lot of challenges and somehow we've got to maintain family function, even if it doesn't look like a typical family ... divorce, death, AIDS, the structure of family life is changing and family life needs to be healthy, it still needs to meet the family's needs and that's a challenge, not just for the individual's health but for the health of a community ... I almost feel that if family therapy isn't becoming a focus we're going to lose everything ... there's still a need for individual counselling, for community support and resources, none of it can work in isolation ... but I think its (family therapy) *got the maximum impact as far as intervention goes ...".*
The respondent went on to emphasise however, that as an intervention family therapy is expensive, difficult to coordinate and challenging in terms of practicality.

Two of the respondents mentioned the issue of theory and technique, albeit from a different perspective. The hope expressed by one respondent is that the postmodern techniques continue to grow and develop to match theoretical development. Another respondent commented as follows.
"I think it would be useful if new ideas and approaches were developed ... a lot of it (family therapy) *is focused around quite a limited body of theory relating to family therapy ... that might be in terms of Family Life Centre, what they provide ...".*
The issue for this respondent is the lack of theoretical preparation provided by the Centre, which may contribute to a sense of inadequacy and lack of confidence in practice.

The hopes of one respondent centre on the integration of family therapy with other modes of intervention, specifically individual and couple work, and the wish that therapists would work more effectively as team members.

The theme of wider availability is reiterated by a number of respondents, as well as the value of family therapy as a method of intervention. Other aspects of significance mentioned are theoretical preparation and team efficacy.

- **Hopes for your future as a family therapist:**

A number of shared themes emerge from an exploration of the hopes of the family therapy practitioners with regard to their future. Most of the respondents hope to be in a position to do more family intervention, either at Family Life Centre, or in private practice, as their comments affirm.

"To do more, ja".

"I'd like to do more".

"Well, one day hopefully I will be in a position to open up a private practice and I would like to be able to confidently carry out family therapy ... I do really believe that it could be so valuable to so many people, because you know, we all come from a family, those dynamics are life-forming, and um, they can be very damaging ... and if the family heals, gee, its fantastic because there's so many people (impacted on) *... and its perpetuated down the line ...".*

Transgenerational family therapy is based on the belief that family problems are multigenerational phenomena resulting from patterns being replicated from one generation to the next (Carr, 2000:159; Hanna & Brown, 1999:15; Goldenberg & Goldenberg, 1996;165).

"To introduce it to my practice, to consider it as an alternative (to individual counselling) *... but it requires perseverance and flexibility".*

From an alternative perspective, another respondent believes that family intervention may be achieved through work with the parents, as her comments imply.

"To be involved in a different way ... to work with couples because very often I think that's the route ... that's where I see myself and hope to go".

"I'm hoping more and more people will buy into the fact that family life, healthy family life, is where its at ... obviously I'm making this my business (laughs) so the more people that buy into that, the more business I have, but I also believe it's the way to go ... if there's a problem in the family, for the family to come for therapy and interlink that with the individual, that's how I'd like to work ...".

One respondent expressed some reservation regarding family therapy in private practice, as the following suggests.

"... there is place for it in private practice ... but it's harder, there's so many dynamics thrown at you, you become single-lensed and I think a multiple lens in family therapy is crucial ...".

While acknowledging the difficulty of family therapy in private practice, one of the respondents remains hopeful, as her comments indicate.

"That I can continue doing family therapy but with a team, that I would have to access somewhere, somehow ... that would be my ideal ... I would do it on my own without a team, I'd be comfortable enough, but even if I only had one other person watching, its better ...".

The benefit of multiple perspectives is emphasised by both of the respondents above.

In conclusion, most of the respondents believe in the value of family therapy as an intervention, and hope to continue to be involved at some level in the future.

- **Recommendations for practitioners considering participation in the field of family therapy at Family Life Centre:**

A significant theme raised is the issue of experience and preparation relating to family therapy intervention, with some respondents feeling that the lack of these aspects may be detrimental on a number of levels. For other respondents however, the scope for learning

and the enhancement of personal confidence as an outcome of reflecting team work is invaluable. Orlinsky and Ronnestad (in Lebow, 2005:92) explored therapists over their professional life cycle, stating that most therapists view growth as a lifetime task and value continuing development. The comments below testify.

"That is will be the most valuable thing they ever encounter ... and that it's an opportunity that should be used wisely and really relished, because there aren't many opportunities out there to do it ... its really, really worthwhile and your learning just is elevated and increased in leaps and bounds".

"Take the plunge, it can be scary but it's so powerful and rewarding".

"Its very good experience ... you gain in confidence".

"My only recommendation would be that the people coming in on a new level into the reflecting teams would be more oriented towards the methodology of family therapy ... personally I found it a bit, um, it took me time to actually become aware of the fundamentals of it, the method of it ... also I think its quite a difficult thing, because you're working in a team, sometimes I don't want to be negatively criticised, um, told that what I did was wrong, um, I would like to be constructively criticised for something that didn't work, you know ...".

"They should definitely have greater preparation, um, what are the different approaches that are available, what are the different stressors in the family life cycle, to know what areas to look at ... I don't know how much undergrad training they get in that ... I know we did quite a bit in our course but I think it varies ... so if Family Life Centre had something to um,... as a training preparation, even if its self-study, it doesn't have to be formal, just an introduction into it...".

"... ensure good quality and high standards of practice but balance it by allowing it to be a learning experience ... maybe it shouldn't be imposed on interns ... it may be

extremely daunting and some interns really struggle ... maybe they can be part of the reflecting team as opposed to being the family therapist ... if you're filled with your own anxiety, how effective can you be? ... and I don't think just anybody should be doing family therapy, you have to have a certain level of experience ... there are so many dynamics, can inexperienced therapists do harm? I feel they can, through a failure to be self-aware ... my anxiety about family therapy took me back into my own therapy ... it was too much, being a student, being observed, observing the family ... therapy helped me manage".

"I would say that you should have to have a certain amount of time practicing therapy before you can just go into family therapy, because I think, uh, you can't have a reflecting team with five interns and one professional ... there's potential for things to go wrong ... and I know its not cost-effective but you will never hold good therapists unless they have a burning desire and passion (for family therapy) *if you expect them to earn very little ... I'm not sure how it can be resolved* (at the organisation) *...".*

A further issue for this respondent is the practical requirement of evening work for the reflecting teams, as her remarks elucidate.

"... family therapy requires time, and I think that deters a lot of people ... its in the evening which is practical for the family ... but a lot of therapists don't want to work at night".

The importance of knowledge on many levels was emphasised by one of the respondents.

"Know your family-of-origin, know yourself, know who you are, where you come from, know your triggers and know systemic work ... and read!".

Flexibility regarding family intervention was stressed by one respondent, as her comment suggests.

"Go into it with an open mind and take from it what you can and give to it what you can, but don't allow it to define how you work with families".

In conclusion, the recommendations of the respondents centre on the value of family therapy in a reflecting team as invaluable to learning, both personally and professionally. Additional theoretical preparation is mentioned as important, as is preparation for the person of the therapist. Consideration of the potential impact that lack of experience may bring to the anxiety of interns, possibly to the detriment of the client family was alluded to.

The themes relating to recommendations tend to blur into one another, and certain aspects mentioned in this category are also mentioned in the next.

- **Recommendations to Family Life Centre regarding the practice of family therapy:**

The significance of preparing families about to enter into family therapy was stressed by one respondent, who had the following to say.

"Prepare the family for the practicalities of having the reflecting team ... and acknowledge the level of investment for the family".

While families are given as much telephonic information as possible prior to the first session, from the experience of the researcher, that initial session often still comes as something of a shock to many families. From the perspective of the researcher, it is possible that the whole process is so strange and out of the realms of most peoples' experience that full preparation is almost unachievable.

Education and training are important points for some of the respondents, who commented as follows.

"I think they (Family Life Centre) *should be encouraging people to go and do things like the family therapy masters ... obviously not everybody who does family therapy is going to do a masters degree, but they need something more in the way of understanding ... because you have to base your practice on theory and I think that was to me very scary, people going in unprepared ... and how fair is that to the family?".*

"Supervision of the team … and also more workshops and input from experienced family therapists who could add to the training … more discussion on theory, and on integration of theory and practice".

Effective supervision is a way to prevent burnout, and according to Grosch and Olsen (1995:284), supervision should take place outside the work setting, have no evaluative function and provide a theoretical orientation that is suited to that espoused by the supervisee.

One respondent believes that Family Life Centre could do more in terms of advertising family therapy, to enable it to become better known in the wider community. The issue of improving facilities and equipment was also emphasised by this respondent as well as a few others.

"… I must say it would be nice to have better facilities and things … just in terms of bumping into each other in that little passage … I don't know, if there were two exits and entrances, so you didn't have to literally bump and shift around (laughs)".

" … it's a wonderful service but it's expensive (in terms of resources) *… it would be nice if they had a two-way mirror and not everyone had to turn in the passage (laughs)".*

"… and also, just logistically, the flow from one room to the other, I don't know how that can be better facilitated or even if it can but …".
This respondent, as well as a number of others, explored the issue of team composition and team compatibility, as the comments below illustrate.

"Its difficult, um, the selection of people onto the team is critical, but I'm not sure how much that can be controlled … um, power balances and those kind of things I spoke about, which will influence the team …".

"I think that the team should, before starting off the year, the team should get together, to discuss their mode of working, are there any changes they want to make, can they all work in this way, are there other ways they want to start bringing in … um, and no chitter chatter behind the mirror, I think its disrespectful, so to uphold respect at all times … and in the feedback, I think its very important to discuss how challenging are we going to be, how authentic can we be in the feedback, otherwise its just a performance …".

"I think that maybe the reflecting teams could be alternated, and that leaders of reflecting teams be alternated to get a different perspective of different training styles and learning styles … to get more exposure to different styles"..
This theme was one raised by another respondent who commented similarly.

"I think they should have some sort of meeting together of all the teams, that there should be a mixing up of people so that you don't get two people becoming reliant on each other and then the others sit back and relax, or they don't get the benefit maybe … I don't think it should become so familiar that um, the others sort of feel like outsiders …".
The respondent expanded further to state that at Family Life Centre there is a tendency at times to put all of the interns in one team, all of the social workers in another, which may lead to a comfort zone that is not necessarily beneficial.
"… social workers come with different perspectives from psychologists and it would be good to mix the teams … you don't want teams where everyone is totally at sea but, um, if they met on a monthly basis and had some sort of theoretical discussion or whatever, and maybe through dialogue become more familiar with different ways of working … get to know other people … even team leaders have a way of doing it and you can learn from each other … maybe team leaders can step down and play different roles … it could be beneficial".

Of importance too, for a respondent is the issue of what the focus of the team's reflections should be.
"… how to shorten our reflections, how to focus that, what are we going to choose to focus on, what are we going to emphasise … I don't know quite how to do that …

individually we are in different places of growth and I don't want the assumption to be that we know what we are doing (laughs)".

And finally, one respondent believes that issues such as the number of teams and number of families awaiting intervention are significant. Her comments elucidate.
"I just wish, sometimes I wonder if there were more teams and more families being seen whether we would be under less pressure to get things done in a certain amount of time ... you know, like there's a very long waiting list and other people in the team need a turn (to be the primary therapist) *... it doesn't always lead to optimal outcomes".*

Many recommendations to Family Life Centre are mentioned by the respondents, which clearly illustrates their keen interest and hopes for the future of family therapy and reflecting team practice in the future. Issues explored include better preparation for the family prior to the initial session, improving education and training, introducing team supervision, contemplating team composition and at times, changes in composition to facilitate alternative narratives in learning, and finally, improving the practicalities of the facilities at the Centre.

- **Further comments:**

Two respondents had additional comments to add to the themes relating to the future of family therapy practice.

"I always feel uncomfortable that the team isn't introduced to the family and I've often wondered why ... because in some the writings I've read, the team is introduced and in fact the clients are given a chance to actually question their qualifications and all sorts of things ... it just feels um, more civil, uh, better mannered (laughs)".

Madigan (in Lax, 1995:148-149) explores the issue of facilitating the opportunity for clients to ask questions of the team during the interview. Their questions may lead to the development of new avenues of dialogue that could be explored, or even to asking about team members' own thoughts and feelings, and the impact of the session on them.

"I think I've learned a lot and its confirmed stuff for me, which is always useful to have, ja".

An opinion expressed by the researcher (Chapter 4:230) suggests the need for paradigmatic exploration, if only to consolidate one's original position, or to contemplate a possible shift.

Consideration of what may feel comfortable for the client family and for the self of the therapist are additional aspects mentioned by respondents.

5.5 SUMMARY

In this chapter the research methodology was discussed, and the qualitative research findings were analysed and interpreted.

The qualitative research findings were the results of data obtained from nine (9) respondents who were family therapy practitioners at Family Life Centre during the research period. The findings were analysed and interpreted in conjunction with the format of the interview schedule and with reference to the literature review.

Family therapy practice requires not only an understanding of the epistemological shifts that have occurred in the theoretical arena, but also of the impact of the self of the practitioner on the therapeutic encounter and thus, therapeutic outcome. Theory that is authentic to the self of the family therapist has the potential to be experienced as healing and effective for the client family and by default, for the personal and professional growth of the therapist. Reflecting team practice is the cornerstone of training provided at Family Life Centre, conferring a potentially enriching experiential learning environment. The development of the personal and professional self is an ongoing process, one that is idiosyncratic and unique to each therapist.

In this research study, the epistemological shifts in the field of family therapy were explored, as were aspects relating to theory and intervention. The experience of

participation in a reflecting team was investigated, as was the development of the personal and professional self, with issues relating to burnout being considered. The findings highlight the importance of a constellation of all of the studied factors in the development of the family therapy practitioner.

In the final chapter, the chapters relating to the literature study, as well as the chapter relating to the empirical findings will be summarised and concluded, and recommendations with regard to the study will be made.

CHAPTER 6

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

6.1 INTRODUCTION

In this the final chapter, a summary overview of the previous chapters will be presented. Conclusions will be drawn from both the literature and the qualitative findings, and certain limitations of the study will be briefly contemplated. Finally, recommendations will be made with regard to the empirical study, the role of the family therapy practitioner and areas for further study.

6.2 GENERAL ORIENTATION

The summary of, and conclusions from, Chapter 1 follow.

6.2.1 Summary: General Orientation

In Chapter 1, the following aspects were addressed: introduction; problem formulation; purpose, goal and objectives of the research study; research question; research approach; type of research; research design and methodology; pilot study; description of the research population, sample and sampling method; definitions of key concepts; contents of the research report.

6.2.1.1 Goal

The following goal was formulated:

- **Goal of the Study: To explore the perceptions, opinions and experiences of family therapy practitioners in relation to: the impact of epistemological shifts in the field of family therapy on practice and intervention; the espoused theory/ies; reflecting team practice; the development of the personal and professional self.**

The goal of the research study was achieved, in that an understanding of the perceptions, opinions and experiences of family therapy practitioners with regard to theory, the intervention process, reflecting team practice, and the development of the personal and professional self was obtained. The implication of the epistemological shift in the field of family therapy was explored, together with an investigation of theoretical and experiential training and the significance of the development of an authentic self.

6.2.1.2 Objectives

The objectives of the study were based on an exploration of the literature as well as on the empirical study.

Literature:

- **The origins and history of family therapy, as well as an overview of the approaches to family therapy.**

The objective of gaining knowledge regarding the origins and history of family therapy and an overview of the numerous theories/approaches to family therapy was accomplished. An in-depth understanding of these concepts and aspects was obtained. In addition, the notion of integration of modern and postmodern thinking was addressed.

- **A comprehensive theoretical orientation that will attempt to consolidate and deepen critical understanding of the different approaches to family therapy.**

The objective of providing a comprehensive theoretical orientation with regard to the many theories relating to family therapy practice and intervention was achieved, the aim being to facilitate the consolidation and/or deepening of a critical understanding of the various approaches.

- **Epistemological shifts in the field of family therapy.**

Through an exploration of the epistemological shifts in the field of family therapy, in particular the development of postmodern thinking and related concepts, this objective was realised. A deeper understanding of the epistemological shifts and the implications thereof was gained.

- **The impact of exposure to such shifts on the development of an authentic professional self, the integration of personal and theoretical beliefs, and the capacity for enhanced reflexivity.**

Through exploration of such epistemological shifts and the opportunity to contemplate the potential impact on the self, insight into the integration of personal and theoretical beliefs and the necessity of such in order to become increasingly authentic in practice, and to develop the capacity for enhanced reflexivity was achieved.

- **The reflecting team approach to family therapy as a method of sensitising the therapist to the multiplicity of perspectives and personal paradigms that exist in family therapy practice.**

The objective of an exploration of reflecting team practice in family therapy was realised. An enhancement of an understanding of multiple perspectives and ways of being, for both client family and family therapy practitioner was explored.

Empirical study:

- **The perceptions, opinions and meanings given by family therapy practitioners to their espoused theories and the impact of epistemological shifts on the professional self.**

The exploration of the perceptions, opinions and meanings given by family therapy practitioners to their espoused theories and the impact of epistemological shifts on the professional self was accomplished. Insight into the meanings theories hold for the respondents, the fit with the self and thus the effect on practice that is experienced as authentic to the self of the practitioner, as well as the client family, was gained.

- **An exploration of how the family therapist may evolve in the context of enhanced theoretical knowledge, experiential training and critical reflexivity towards the development of a more authentic self and thus more competent and confident family therapy practice.**

In exploring the theoretical knowledge, experiential training (specifically in the context of reflecting team practice) and the personal/professional experiences of the respondents in relation to family therapy practice, insight was gained into how such aspects may combine to impact on the capacity for reflexivity and thus on the development of a self that is authentic in practice, with an enhanced sense of competence and confidence.

- **Conclusions that will emanate from the findings to provide a systematic, scientific body of theoretical knowledge and enhance awareness of the need for a personal paradigm that is authentic to the professional self of the family therapy practitioner.**

The conclusions that emanated from the findings may enable family therapy practitioners to gain an enhanced awareness of the necessity of theoretical knowledge in combination with self-knowledge in order to become more authentic in the practice of family therapy.

- **Recommendations that will be of value to the training of family therapists and the practice of family therapy at Family Life Centre.**

The objective of making recommendations that will assist family therapy practitioners to develop an understanding of the need for an enhanced theoretical knowledge, awareness of the impact of experiential training, and the need to be reflexive with regard to the personal and professional self was achieved.

6.2.2 Conclusion: General Orientation

The field of family therapy is immense and complex in its evolution from first-order cybernetics to the postmodern paradigm. Epistemological shifts have illuminated family diversity and the practice of family therapy, allowing for the development of new and effective ways of working with client families in distress. A failure to differentiate between paradigms may hamper the practice of family therapy. In addition, the involvement of the family therapy practitioner impacts on the family system, necessitating an exploration of the personal and professional values, and introspection into how these may affect both intervention with the client family and the authenticity of the self of the practitioner in practice.

To be both effective and authentic, the family therapy practitioner must have access to training that is both theoretical and experiential, as well as opportunity to reflect on the development of the personal/professional self.

Family Life Centre is well placed to achieve a balance of the training aspects, providing experiential training that is unparalleled. The theoretical component has, in the past, been noticeably lacking, while the self aspect is, and should be, a personal journey undertaken by the practitioner, albeit within a context that illuminates the necessity for such an undertaking.

6.3 LITERATURE STUDY

The literature study achieved the objectives outlined above. The summary and conclusions of family therapy theory and the intervention process, the use of the reflecting team in family therapy, and the development and use of the self in family therapy follow.

6.3.1 Family Therapy Theory and the Intervention Process

In Chapter 2, family therapy theories and the intervention process were explored. The salient aspects are summarised as follows.

6.3.1.1 Summary

- **An historical overview of family therapy**

In this section, the historical roots of family therapy were explored, focusing on the developments that laid the foundations upon which family therapy was constructed. These developments are: psychoanalysis; general systems theory; the role of the family in schizophrenia etiology; marital counselling and child guidance; and, group therapy techniques.

- **The evolution of family therapy from the 1950s to the present**

The evolution of the field of family therapy throughout the decades was discussed in this section, with attention given to the history and evolution of family therapy in South Africa.

- **Theories of family therapy**

An overview of the numerous theories of family therapy as classified by Carr (2000) was outlined in this section. Theories that focus on behaviour patterns included: MRI brief therapy; strategic therapy; structural therapy; cognitive-behavioural therapy; and, functional therapy. Theories focusing on belief systems included: constructivist therapy; the original Milan school therapy; social constructionist therapy; solution-focused therapy; and, narrative therapy. And finally, theories that focus on context included: transgenerational therapy; psychoanalytic therapy; attachment-based therapy; experiential therapy; multisystemic therapy; and, psychoanalytic therapy. Included in the discussion of family therapy approaches, were the postmodern feminist approach and existential family therapy. In addition, multi-cultural considerations in family therapy received attention.

- **Intervention**

In this section, family therapy intervention was explored, once again using the categories of Carr (2000) to delineate the interventions according to the various family therapy approaches. Intervention was looked at in terms of behaviour patterns, belief systems, and context.

- **Integration**

The idea of an integration of modern and postmodern thinking in the field of family therapy was explored in this section.

6.3.1.2 Conclusions

- It appears that the 1950s is identified as the period when researchers and practitioners began to focus on the role of the family in the creation and maintenance of psychological disturbance in one or more family members (Goldenberg & Goldenberg, 1996:65). An increase in social problems after World War II meant that other solutions were needed to deal with an array of problems associated with families.
- Five scientific and clinical developments laid the foundation upon which family therapy was constructed. Psychoanalytic theory, particularly the work of Freud, had dominated Western psychiatry, gaining ascendancy within various professions, including social work and psychology. General systems theory and cybernetics, originally presented by biologist von Bertalanffy, was an attempt to provide a comprehensive theoretical model encompassing all living systems and a framework for understanding the interrelatedness of subsystems. The focus was on circular causality. Bateson is viewed as the single most influential figure in the history of family therapy, developing a unified framework to explain mind and material substance (Gladding, 2002:65; Carr, 2000:57). Early studies focused on the role of family dynamics in the development of psychopathology, specifically schizophrenia. The connection between family environment and schizophrenia remains at the forefront of family systems research. Marital counselling and child guidance are

viewed as the "…precursors of family therapy", based on the concept that psychological disturbance arises from both relationship conflicts and inner conflicts (Goldenberg & Goldenberg, 2000:90). Developments in group therapy focused on helping people identify their self-defeating behaviour patterns, a technique that was included in family therapy.

- Family therapy evolved from these developments, with growth and controversy characterising the theoretical arena. The decade of the 1950s is filled with the names of people who made enormous contributions to the field, including Bateson, Haley and Satir to name a few, and the Mental Research Institute was founded in this decade. According to Gladding (2002:66), the 1960s was an era of rapid growth in family therapy, with the founding of the first family therapy journal (*Family Process*) and the pioneering work of Minuchin which resulted in the development of the structural approach. In addition, the work of Selvini-Palazzoli in Italy had a worldwide impact on family therapy. The decade of the 1970s was marked by the growth and refinement of family therapy theories, as well as critique of family therapy by the feminist movement. Family therapy continued to grow in the 1980s, with models mostly based on systemic thinking. The work of Maturana, Varela, von Foerster and Von Glaserfeld began to filter into the consciousness of family therapists, challenging the first-order approach (Hoffman, 1990:2). The 1990s saw a shift to integration and eclecticism as theories overlapped and blurred. New and controversial epistemologies challenged systemic assumptions and the view of an objective reality.
- According to Kaslow (2000:1), the evolution of family therapy in various countries has followed a similar course, with some deviations reflecting the differing social, political and cultural contexts. Over the decades, extensive education in the form of workshops, conferences and so on have taken place in South African, bringing a wealth of knowledge and experience to the field of family therapy.
- The field of family therapy is extensive and extremely complex, with no simple classification system existing that does not simplify, conceal or subdue many of its nuances (Pocock, 1999:188).

- Carr (2000) classifies the many schools of family therapy according to the central focus of therapeutic concern, namely: theories that focus on behaviour patterns; theories that focus on belief systems; and, theories that focus on context.
- The theories that focus on identifying problem-maintaining behaviour and attempts to disrupt them generally have problem-resolution as the primary goal. Structural and strategic models emphasise the importance of the organisational structure of the family in contributing to family dysfunction. Personal growth is not a major concern with these approaches and treatment tends to be brief.
- The theories that emphasise belief systems share a rejection of positivism and a commitment to an alternative epistemology (Carr, 2000:110). These approaches focus on the belief systems that form the bases of problematic interaction patterns. Some of the approaches explore exceptions to the problem, and solutions over and above problems. Feminist and gender-sensitive family therapy attempts to transcend sex-role stereotypes, while logotherapy is directed at the search for meaning.
- Theories that focus on contextual factors highlight the view that people may be predisposed to the development of behaviours and beliefs because of factors in their family history, the wider social network, or personal constitutional factors such as genetic vulnerability. Experiential family therapy differs somewhat in that it includes both problem-resolution and personal growth as therapeutic goals. Multisystemic family therapy addresses factors in the wider social system as well as individual factors, while psychoeducational models consider constitutional and genetic factors in predisposing people to problematic behaviours and beliefs (Carr, 2000:176; Goldenberg & Goldenberg (1996:323). Culturally sensitive practice in a diverse society is extremely challenging, but shows promise in working with families from differing cultures (Lee, 2003:386).
- Carr (2000:255) again uses the categories of behaviour, belief and context to delineate appropriate intervention techniques according to the schools of family therapy. Techniques relating to behaviour change include: creating a therapeutic context; changing behaviour patterns within sessions; tasks between sessions; changing behavioural consequences; and, invitations to complete tasks. Techniques relating to belief systems include: addressing ambivalence; highlighting strengths; reframing the

problem; presenting multiple perspectives; externalising problems and, building on exceptions. Techniques aimed at modifying the impact of historical, contextual and constitutional factors or techniques that mobilise protective factors include: addressing family-of-origin issues; addressing contextual issues; and, addressing constitutional factors.

- The views of a number of authors on the topic of integration explored the encompassing of both modern and postmodern views, thus combining a both/and approach to family counselling. The postmodern paradigm has ensured that family therapy remains sceptical of its assumptions, respectful of the unique solutions of families and an emphasis on the person of the therapist.

6.3.2 The Reflecting Team in Family Therapy

In Chapter 3, the reflecting team approach in family therapy was explored, the main points of which are summarised as follows.

6.3.2.1 Summary

- **Dialogue in the therapeutic conversation**

The concept of a dialogical conversation, as opposed to monological dialogue, was explored in this section.

- **Tom Andersen's reflecting processes**

The personal journey and reflections of Tom Andersen with regard to reflecting team work were examined, with attention given to Andersen's guidelines for the practice of a reflecting process.

- **Alternative stories in using reflecting teams**

Various alternative ideas explored the use of reflecting teams, including working in a reflecting team from a narrative perspective. Also touched on was contemplation of

occasions when reflections are not useful to client families, as well as the development of self-reflection in an endeavour toward transparent practice.

- **The reflecting team process in training**

In this section an examination of the use of reflecting teams in training was undertaken, with some guidelines set out for the use of reflecting team specifically in a training setting. In addition, possible disadvantages of the use of reflecting teams in training were considered, as was the use of peer reflecting teams as a way to contribute to family empowerment.

- **Training in reflective thinking**

Aspects relating to training in reflective thinking were touched on in this section.

6.3.2.2 Conclusions

- The use of teams in family therapy occurs in many schools of therapeutic intervention, although they are used in different ways. The reflecting team model was first introduced by Tom Andersen in the 1980s as an alternative to the Milan style team (Biever & Gardner, 1995:47). The use of the reflecting team allows the client family direct access to the perspectives, ideas and speculations of the team members.
- According to Anderson (2001:112), language, both spoken and unspoken, gains meaning through its use. A dialogical conversation refers to one in which people talk with, rather than to, each other. Dialogical language engages the family from the beginning of the therapeutic process. Monological forms of interaction are a specific part of dialogue, but tend to prohibit the flow of questions and shut down discourse. In addition, monological dialogue is hierarchical, while dialogical conversation is democratic, engaging the family as co-creators of the therapeutic journey which may provide alternative meanings and solutions to a problem.
- Tom Andersen became disenchanted with monological and hierarchal systems that allowed no room for the voices of the family to be heard above that of the therapist. In his own growth and evolution as a family therapist, it is apparent how he came to

practice reflecting processes, which he sees as hermeneutic circles (Andersen, 1995:12). Other reflecting processes can be described as shifts between talking and listening – in this process of sifting issues, a number of alternatives may be put together to create new ideas.

- A number of guidelines for the practice of a reflecting process that are consistent with postmodern thinking were suggested by Andersen (1995:19-21; 1987:424). Aspects include ensuring that the process is spontaneous, natural and comfortable; presenting ideas tentatively; being circumspect with comments on non-verbal behaviours; separating the listening and talking positions; using positive connotation; and, using the language and metaphors of the family.
- Some goals and guidelines were explored by different authors regarding alternative ways of reflecting team practice (Friedman *et al.,* 1995:186-192; Zimmerman & Dickerson, 1996:301-302). The alternative stories of different authors regarding the reflecting team process contribute to the generation of multiple perspectives for contemplation by reflecting team members, providing a multiplicity of aspects upon which to reflect, and including questioning the self so as to enhance reflexivity and authenticity.
- The issue of de-emphasising hierarchy in working with families was explored by Cohen *et al.* (1998:290-291). Some useful questions focusing on issues such as 'expertness', transparency, difference, language and evaluation aim to decrease hierarchy and enhance reflexivity.
- Lax (1995:145-146) explored the contention that there are times when the team's reflections are not useful to the family. Aspects considered included reflections being: directionless, confusing, too long, phoney, and, overly positive. Certain guidelines were suggested to address these issues.
- The issue of training in a reflecting team setting was explored by White (1990:76), who states that the expectations of those involved in training and/or supervision are a significant factor. Carlson and Erickson (2001:200) proposed that postmodern thinking offers enormous potential for the training of new therapists, specifically narrative ideas which recognise and honour more personal and local knowledges and skills. In addition, some guidelines were set out by Biever and Gardner (1995:52-54)

relating to the use of reflecting teams in a training setting, as were possible disadvantages of the use of reflecting teams in such a setting (Young *et al.,* 1989:73-74). Despite a number of possible problematic issues relating to the reflecting process in a training setting, the potential for personal and professional growth is evident. The value of dialogue and the exploration of multiple perspectives provide an enriched learning opportunity for reflecting team members.

- Peer reflecting teams, also referred to as audiences or outsider witness groups may allow for creative and pragmatic ideas to emerge in collaboration with people who have had similar experiences to the client family, thus 'thickening' the alternative story and empowering a stuck process.
- Participation in the reflecting team process may create an exceptional learning environment that provides an opportunity to learn from fellow team members in ways that may challenge assumptions about knowledge and facilitate the journey towards reflexivity.

6.3.3 The Development and Use of the Self in Family Therapy

The development and use of the self in family therapy was investigated in Chapter 4.

6.3.3.1 Summary

- **Developing a self**

In this section, the notion of self was explored, with contemplation of aspects such as the connected self and optimal human development.

- **On becoming a family therapist**

Various motives relating to becoming a therapist were noted in this section, including consideration of the interrelated process of developing the personal and professional self of the family therapist.

- **The relationship between choice of theory and the self**

In this section, the relationship between the choice of theory and the self was explored, as were the issues of paradigmatic shift, and the experiential aspects of becoming a family therapist.

- **The therapeutic relationship**

The nature of the therapeutic relationship received attention in this section. In addition, cautionary aspects of the therapeutic relationship and evaluation of the therapeutic role were contemplated.

- **Enhancing self-awareness and reflexivity**

A consideration of possibilities to enhance self-awareness and reflexivity was undertaken in this section.

- **Burnout**

The issue of sustaining the professional self over the career span in order to recognise and prevent burnout was dealt with in this section, with a number of aspects being considered, such as self-assessment, family-of-origin work, assessing the cohesiveness of the self, support groups and supervision and, finding balance.

6.3.3.2 Conclusions

- The notion of the self has provoked curiosity through the ages, with Cartesian thinking emphasising the objective aspect while the existential philosophers drew attention to the subjective experience of the human being (Baldwin D, 1987:28-29).
- Satir (1987:17) emphasised the importance of the self of the therapist as an essential aspect of the therapeutic process, while Baldwin D (1987:33) explored the work of Buber whose view centres on the I-thou relationship, wherein there is an appreciation for the subject and object of each person in a relationship. It is a relationship of reciprocity and the highest expression of mutual confirmation, a key aspect of the definition of the real, present and authentic self.

- The views of McGoldrick and Carter (2005:28-29) on the development of a mature, independent self emphasise a number of skills, and thus the self develops around a structure that contains many variables which interact with one's unique person and environment.
- The connected self is based on recognition of the interdependence of people and is seen as critical to the development of psychological health.
- Differences in male and female socialisation have polarised beliefs about men and women, permeating perceptions of the self. Such differences require a careful use of the self in the arena of family therapy (Collier, 1987:53).
- Human development has implications for the personal and hence, professional self of the family therapy practitioner. The work of Frankl (in Durston, 2005a) explored the optimally developed individual, while the concept of the fully functioning person from a humanistic, person-centred perspective was discussed by Merry (2002:28). A comparison of the ideas of Frankl and Rogers showed many aspects of compatibility and similarity, all of which are relevant to the self of the therapist in both personal and professional life. While no human being is perfect, aspects relating to the development of the self may enhance the capacity for reflexivity and authenticity in family therapy practice.
- Many therapists are drawn to the helping professions in an attempt to understand and deepen the connection with the self (Keith, 1987:61). A number of motivations for the practice of therapeutic intervention were discussed by Goldberg (1986:111-120), including the scholarly, the ethical and the creative motive. The work of Sussman (1995:16-23) explored a number of motivations or 'illusions' that were part of his own journey and which emerged at various times during his professional development, and which may resonate for practitioners in understanding their chosen path.
- The concept of the 'wounded healer' arises often in the literature. It refers to the personal hurts and wounds of the therapist that motivate not only the choice of vocation, but also the power to heal (Viljoen, 2004:28; Miller & Baldwin, 1987:139). Other factors identified as possible motivations for entering the helping professions are sensitivity to emotion, the capacity for observation and reflection, and the

experience of distress in early life (Goldberg, 198653-58). Motives may be subjective or objective and both contribute to practice. The ability to explore and question one's motives for becoming a family therapist enables one to reflect more deeply on the career choice, and is thus an essential aspect of the capacity for reflexivity.

- The relationship between the personal and professional identity of the therapist is continuous, reflecting a dynamic relationship between what is meaningful or significant on a personal level and the theoretical/technical aspects that are learned and practiced (Zeddies, 1999:231). In addition, the development of a therapeutic style is a central developmental task. Many aspects combine to form the self, including personal history and contemplation of theories that resonate with the self, as well as awareness of the impact of the self on the therapeutic encounter with a client family.
- Theory and technique, while necessary to the practice of family therapy, are not sufficient without consideration of the impact of the self of the practitioner in the context of the therapeutic encounter. It would appear that it is the relationship, rather than a particular theory that is experienced as having value for the client family. However, the fit between chosen theory and self is a significant aspect in practice that is experienced as authentic and meaningful for both client and therapist.
- Awareness of one's chosen approach, the fit with the self and ongoing self-reflection is necessary for enhancing authenticity in practice. The paradigm shift from the observed to the observing system in family therapy practice has changed the way family therapy is practiced, and, according to Sexton (1997:11-12), such a paradigm shift requires a refocusing on theory and a possible reformulation of beliefs, a process that may prove difficult and confusing for the therapist. Failure to reflect on one's paradigmatic position and the accompanying assumptions may impact on the therapeutic encounter in unconscious ways.
- A comparison of therapy guided by 'certainty' versus 'curiosity' and of 'power' versus 'empowerment' was explored. (Amundson *et al.,* 1993:118-119).
- Experiential methods of training provide an opportunity to focus on therapist issues and enhance awareness of the self in challenging family therapy situations. The self-reflective process promotes an ethos of self-questioning and self-monitoring that may

prove both beneficial and painful to the self of the family therapy practitioner, but is necessary to the process of enhancing reflexivity and authenticity.

- The therapeutic relationship is the core of psychotherapy, and while a number of factors may enhance this relationship, it also serves as a resource that facilitates, supports and focuses the client's self-healing ability (Tallman & Bohart, 1999:102). Awareness of personal emotional responses, family history and understanding the significance of the impact of the self upon the therapeutic encounter are essential aspects to consider with regard to therapeutic process and outcome.
- Certain dangers may be inherent in the therapeutic relationship and have the potential to be harmful to both the recipients of family therapy, as well as to the therapist him/herself.
- Therapist evaluation of the process is necessary, and a number of questions that may help evaluation were suggested by Hanna and Brown (1999:267). In addition, the issue of client evaluation of the therapeutic experience was considered, with aspects explored by Coulehan *et al.* (1998:25-29) and Treacher (1995:197-219), the latter author promoting guidelines for "…user-friendly practice…".
- Possibilities regarding the enhancement of self-awareness and the development of insight were explored. These included personal therapy, supervision, self-exploration of one's story, and the contemplation of extra-therapeutic encounters (both real and imagined). A number of ways in which self-awareness and reflexivity may be enhanced exist, and are potentially beneficial for the family therapy practitioner.
- Maintaining a life outside of the therapeutic world is vital to minimise stress and the potential for burnout. A number of aspects relating to burnout were explored, and the necessity of finding a balance in one's life to enhance personal and professional growth was emphasised.

6.4 QUALITATIVE RESEARCH FINDINGS

The objectives relating to the empirical study as outlined above (point 6.2.1.2), are discussed below.

6.4.1 Summary

The qualitative findings relating to the family therapy practitioners, discussed in Chapter 4, focused attention on the following summarised aspects:

6.4.1.1 Biographic Details

This section of the findings detailed the biographic data relating to the respondents. Aspects included were: gender; present marital status; age; level of experience as a family therapy practitioner; position held at Family Life Centre; tertiary education; university/ties from which degree/degrees were obtained; counselling history; and, other work experience.

6.4.1.2 Perceptions, Opinions and Experiences Relating to Family Therapy Theory and Intervention

In this section, the perceptions, opinions and experiences relating to family therapy theory and intervention were explored.

- **Family therapy theory**

Data was obtained relating to themes that explored the following: opinions regarding the epistemological shift in the field of family therapy; theoretical approaches; the way the approach/approaches was/were chosen; influence of personal values/beliefs on chosen theoretical approach; impact of chosen theoretical approach on personal/professional life; philosophy of chosen theoretical approach and fit with personal/professional preferences; changes in approach to family therapy; theoretical approaches that do not fit with personal/professional preferences; the way the respondent would have been personally/professionally without encountering the chosen theoretical approach; and, further comments.

- **Intervention**

This section examined themes relating to intervention. These were: consistency between intervention and chosen theoretical approach; contribution of chosen theoretical approach to a positive therapeutic relationship; contribution of self to a positive therapeutic relationship; ways of relating to client families found to be the most helpful; values and beliefs about change in intervention with families; the influence of personal beliefs about change upon intervention with families; messages intervention may send to the families; changes in beliefs about families since entering the field of family intervention; the ways the chosen theoretical approach may have challenged views, beliefs and attitudes regarding intervention with families; importance of being aware of the chosen theoretical approach in intervention; and, further comments.

6.4.1.3 Perceptions, Opinions and Experiences Relating to Participation in a Reflecting Team

The perceptions, opinions and experiences relating to participation in a reflecting team were explored in the themes outlined as follows: knowledge of reflecting team practice prior to participation; expectations of reflecting team practice prior to participation: experience of being an observer of the client family; changes in experience of being an observer over time; experience of being observed by the client family; changes in experience of being observed over time; general impression of participation in a reflecting team; feelings typically experienced during a family therapy session (about the family, team, self); incidents (positive or negative) that may have significantly influenced participation in a reflecting team; learning (skills, knowledge, self) from the experience of participation in a reflecting team; ways in which participation in a reflecting team may have influenced the choice of theoretical approach; feelings when fellow team members evidence different theoretical approaches in family therapy practice; ways in which participation in a reflecting team may have fostered a higher level of self-awareness (personally and professionally); and, further comments.

6.4.1.4 Perceptions, Opinions and Experiences Relating to the Self in Family Therapy Practice

The perceptions, opinions and experiences relating to the self in family therapy practice encompassed the following themes.

- **Personal self**

Aspects of the personal self explored with respondents comprised the following: a description of family-of-origin/family-of-procreation; role in family-of-origin/family-of-procreation and feelings regarding that role; origin of desire to help others; skills or abilities relating to helping others developed in life; the importance of developing these skills; experiences in life that invited entry into the field of family therapy; significant influences that nurtured an interest in the field of family therapy; aspects of self brought to the family therapy context; awareness of personal responses during the therapeutic encounter; knowledge of when/when not to use personal responses to facilitate the family therapy process; personal qualities believed to be critical to the use of self in the family therapy context; discussion of the way a personal crisis was dealt with and resolved – new outcomes or conclusions that became available and contributed to family counselling career; ways in which family therapy practice may have affected personal life; and, further comments.

- **Professional self**

The section on the professional self examined themes relating to the following: a description of the career story (i.e. personal experiences that contributed to the decision to be a family therapy practitioner, resolution and outcome that may have shaped the counselling career); preferred ways of being as a person and as a family therapy practitioner; experience of fit between preferred ways of being as a person and as a family therapy practitioner; hopes about how families experience themselves when with the respondent; awareness of professional role during a therapeutic encounter with a client family; beliefs about the impact of the professional role on the client family;

awareness of client issues that challenge or contribute to feelings of discomfort for the respondent; and, further comments.

- **Burnout**

The following aspects were contemplated with regard to the issue of burnout: level of satisfaction (or not) with work as a family therapist at Family Life Centre; level of satisfaction (or not) with personal life; sustaining the career as a family therapy practitioner; challenges to the ability to sustain the self; and, further comments.

6.4.1.5 Opinions of Family Therapy Practitioners on the Future

The themes explored focused on the opinions of family therapy practitioners regarding the future: hopes for the future of family therapy; hopes for the future of the respondent as a family therapist; recommendations to practitioners considering participation in the field of family therapy at Family Life Centre; recommendations to Family Life Centre regarding the practice of family therapy; and, further comments.

6.4.2 Conclusions

Conclusions regarding the qualitative findings are discussed below.

6.4.2.1 Biographic details

- The findings of the study are based on the responses of 9 female respondents. All of the respondents are married, with one exception, a respondent who is engaged to be married. Respondents ranged in age from 27 to 57 years of age, with most in their thirties or forties. Experience in family therapy practice ranged from 7 months to 6 years.
- From the findings it transpires that none of the respondents were in family therapy practice in the decades of the 1980s and 1990s. Thus it may be assumed that the filtering into consciousness of epistemological shifts in thinking about the family

system has not been part of the lived experience of this sample of family therapists. The respondents in this study with the most experience in family therapy had five to six years practice experience, thus excluding any of the respondents from having experienced first hand the criticisms and advances of the decades of the 1980s and 1990s. Thus, knowledge of the shifts would be primarily theoretical, rather than experiential.

- All of the respondents were staff members, sessional workers or interns, and all have the necessary tertiary education that qualifies them to practice family therapy, albeit that some are still completing studies. Exploration of counselling experience showed much variation, as did other work experiences, adding to the richness of the respondents' life experiences.

6.4.2.2 Perceptions, opinions and experiences relating to family therapy theory and intervention

Theory:

- From the findings on the epistemological shifts in the field of family therapy, it was shown that not all of the respondents were clear about the distinction between modern and postmodern paradigms, but did have an understanding of the different theories when mentioned by the researcher (e.g. structural, narrative). This uncertainty highlights the researcher's experience at Family Life Centre, of an insufficiently comprehensive theoretical orientation that consolidates and deepens critical understanding of the approaches and shifts in the field of family therapy. In addition, not having been in practice is the decades of growth and challenge in family therapy theory may also impact on a clear understanding of the different paradigms. Two of the respondents felt that they are too inexperienced to have a real opinion regarding the epistemological shift that has occurred in the family therapy arena over the past decade. This suggests that the potential impact of the shift is less for family therapists new to the field. Other respondents had a clearer understanding of epistemological shifts, viewing it as positive. Thus despite, for some, there being a sense of inexperience or a lack of certainty regarding what constitutes a modern and

postmodern distinction, all of the respondents view the changes as positive in terms of theoretical growth and the move from the expert role to one that is more collaborative.

- The findings relating to chosen theoretical approach reveal that all of the respondents follow a cybernetic epistemology, albeit that the distinction between first- and second-order paradigms is not necessarily delineated. Systems theory and narrative theory were mentioned as the approaches used at the organisation under study. During the exploration of this theme, most of the respondents indicated some shift in their approach to family therapy as their experience in the field grows.
- From discussion on perception regarding the initial encounter with an approach/approaches, it would appear that many of the respondents initially struggled to make sense of family therapy theory, although a sense of the personal embodiment of theory evolved, or is in the process of evolving, over time. The theme of eclectic practice arose, as did the fit between theory and intervention, for some respondents.
- From the findings on the theme of how a theoretical approach was chosen it can be concluded that training institutions and practice organisations impact strongly on the way in which a theoretical approach is chosen. The respondents' personal experience of therapy also impacts to an extent on practice. The personal embodiment of theory occurs perhaps, with enhanced personal and professional experience and development.
- The findings on personal values and theoretical approach were strongly linked in the perceptions of the respondents. The importance of knowing one's values, having theoretical knowledge, knowing which theoretical aspects fit with the self, clearly impact on the choice of approach. However, as explored earlier, choice of theoretical approach is also affected by academic training and the approach favoured in the organisation, which may at times create a degree of conflict. This does not imply however, that personal values are less significant.
- The impact of the chosen theoretical approach on the personal and professional self was felt to impact to a differing degree by the respondents. Some respondents experience the impact strongly, others less so. For one respondent there is a sense of conflict and confusion as a result of not being able to put into practice the techniques of narrative therapy, despite a feeling of real comfortableness with the philosophy

behind it. Other respondents view their theoretical training as providing a platform from which to work, that impacts on how they practice, but which is motivated by their personal beliefs.

- From the findings regarding the philosophy of the chosen approach and the fit with the self, it would seem that the journey towards finding an authentic fit with regard to self and theory is a challenge that may prove ongoing. It seems that there may be times in the career of the family therapist when the fit is more or less comfortable, with the latter providing the motivation to explore other paths and directions. For one respondent, the philosophy of the reflecting team approach, i.e. helping families in difficulty, was a comfortable fit, while the actual methodology of reflecting team practice was less comfortable.
- It would appear that the sense of confusion and lack of confidence in practice that may ensue from a shift in chosen approach was not in the realms of experience in terms of most of this sample of family therapy practitioners. While change has taken place, it seems to be experienced as positive and growth-enhancing. However, for one respondent, the approach favoured at Family Life Centre has caused her to challenge her thinking with regard to the issue of depth in working with families.
- From the findings it can be concluded that cognitive-behavioural and psychodynamic approaches seem to be the least popular approaches in terms of fit with personal and professional preferences. Conversely however, the psychodynamic approach was viewed by a few respondents as extremely valuable in family therapy. Other less popular choices mentioned by the respondents were structural family therapy, existential family therapy and social constructionism.
- The impact of early training, with its focus on more individualistic rather than systemic thinking was evident in the responses to the theme of how the respondents would have been if they had not been exposed to their chosen approach. The initial adherence to a particular paradigm seems to shift over time and with experience, suggesting that the respondents are on their own journey of discovery towards an authentically meaningful way of being in family therapy practice. For a few respondents, the initial encounter with an approach felt authentic and thus change is unnecessary at this juncture.

- Additional findings relating to theory focused on the importance of keeping abreast of developments in the field, the importance of the fit between the therapist's personality and philosophy, and a belief that authenticity, or a lack thereof, impacts on the effectiveness of the therapy with the client family. The search for such congruency may be ongoing.

Intervention:

- From the findings it may be concluded that the fit between intervention and theoretical approach is not necessarily an easy one, at times perhaps not even a conscious one, with intervention often coming from an intuitive level of feeling right for the therapist with sensitivity to the needs of the client family. For some respondents however, the sense of congruency is more felt.
- The conclusions relating to the theme of impact of chosen theoretical approach on the therapeutic relationship suggests that the respondents believe that their chosen theoretical approach contributes positively to the therapeutic alliance. The non-expert role was favoured and respect for the client family's needs acknowledged.
- The respondents place enormous value on the therapeutic relationship and see the self as an important aspect of developing this alliance. Many of their personal/professional values were evident in their responses, such as honesty, realness, and respect for the client family, and being present during the encounter.
- Despite some differences, it would seem from the findings that the respondents were aware of the impact of their way of being on the therapeutic relationship, endeavouring to create a safe space in which the family can explore. Many similar values to those expressed in the theme above were emphasised.
- The meaning of change for the respondents is idiosyncratic, relating to how they see the family and the way in which they prefer to work with the family. Expectations regarding responsibility for change were explored and, it would seem, are likely to be related to the self of the therapist, as well as the chosen therapeutic approach. For some, change is difficult for families and expectations centre on what is enough for the family, while for other respondents, a lack of change by the family may be experienced as frustrating.

- All of the respondents acknowledge the influence of their personal beliefs regarding change upon intervention, however the actual belief systems show some variation. Some emphasise the necessity of client responsibility for change and working at their pace, while others feel perhaps that their own expectation of change may motivate the client family. Perhaps there is at times, a sense of inner conflict between 'saving' and 'supporting', with the therapist walking a fine line between the two.
- From the findings, variation regarding the messages interventions may send to the family was apparent. Again however, the values of the respondents were in evidence and the messages family therapy practitioners aim to impart centre around respect, hope of change, client self-determination, support for the process, and at times, challenge of belief systems such as paternalism.
- For some respondents, family therapy practice has not significantly changed their views or beliefs with regard to families. For others however, a shifting perspective is evident in their response to the uniqueness and difference of client families. Another aspect touched on is the power of the family to be destructive to some or all of the family members, a disturbing view for some respondents, which has grown over time and with experience of working with families.
- All of the respondents believe that their chosen theoretical approach has challenged their views and attitudes towards intervention with the client family, although the extent of the challenge varies. From the findings, the issue that stands out was the sense that there is no particular theory that fits all families and problems, thus challenging the respondents to be flexible with regard to the appropriateness of intervention.
- It can be concluded that opinion varies with regard to the theme of awareness of chosen theoretical approach in intervention with client families. For some respondents the awareness is more in the background, while for others its importance in terms of fit with self and the espoused theory was emphasised.
- The issue of skills development, the ability to facilitate the family therapy process and go at the pace and in the direction of the family were comments added to the themes relating to intervention.

6.4.2.3 Perceptions, opinions and experiences relating to participation in a reflecting team

- Conclusions from the findings reveal that the respondents had either no knowledge of reflecting team practice prior to participation, or had a little theoretical knowledge gained during university training. For most of the respondents, the encounter with reflecting team practice at the Centre was their first introduction to this way of working with client families, thus family therapy work done at Family Life Centre is significant in terms of training, both theoretical and experiential.
- The expectations of reflecting team practice prior to participation showed some variation, with some respondents having few, if any, expectations, while others had differing levels of expectation. There appears to be a difference between a theoretical understanding and actual experience, and the expectations of the respondents, or lack thereof, impacted on the early experience and perception of reflecting team practice.
- With regard to the experiences of respondents observing the client family, much variation was evident. For some, the initial experience focused more on how they felt observing fellow family therapy practitioners in action, although this focus shifted to the family over time. Perhaps this indicates the anxiety inherent in exposure for practitioners new to the field, and their need to observe fellow team members, and perhaps compare or evaluate their own level of competence. The opportunity for learning through observation seemed to be valued by the respondents, while the experience of being an observer of the client family ranged from feelings of anxiety regarding their 'turn', to one of awareness of power differences in the team and a need to be 'careful' and not do harm. A feeling of privilege at being able to observe the family and other practitioners at work and conversely, to some extent, a sense of voyeurism that was perceived as uncomfortable to some of the respondents were other significant aspects.
- Changes in the experience of being an observer revealed some differences. Most respondents felt that the experience has become easier with time. It appears that with experience, confidence and comfort increase, and the opportunity to learn from colleagues was valued. For some respondents however, an element of anxiety

relating to the efficacy of fellow team members arose, contributing perhaps to the evaluative component inherent in a training setting.

- It appears that the experience of being observed by the client family is not an easy one for most respondents, at least initially. The need to develop a therapeutic style that is authentic, and a feeling of discomfort at times with the styles of other therapists, was an aspect mentioned, as well as issues around anxiety, the lack of theoretical material and/or training which contributes to anxiety, and the need to contribute to the family therapy process in a way that is experienced as healing for the family.
- The experience of being observed becomes easier with time for most, but not all of the respondents. With experience comes a sense of enhanced confidence and lessened anxiety, although as will be observed, anxiety is a 'thread' that runs on some level through the entire range of findings. The advantage of multiple perspectives for both the client family and the reflecting team members was an issue of importance mentioned by some of the respondents.
- The general impressions of reflecting team participation ranged from positive to ambivalent. The issue of the potential for personal/professional growth, team support and the opportunity to learn were identified themes. More ambivalent views focused on frustration with the team approach that does not allow for challenge, anxiety about fellow team members and their contributions to the process, issues of power and hierarchy which may interfere with learning, and disappointment that personal issues and egos may influence the reflecting team process.
- A range of feelings experienced by respondents during a family therapy session were explored. Again, anxiety on many levels was mentioned – anxiety for self, for the family and for fellow team members, as well as frustration with team members. The evocation of personal feelings and responses during family therapy encounters illustrated the self-awareness and capacity for reflexivity of the respondents.
- Incidents impacting upon team members focused on aspects relating to being a member of the reflecting team, rather than on issues relating to the practice of family therapy in a team context. The composition of the reflecting team seems to have enormous impact on the experiences of the respondents. For some respondents, a lack of sensitivity to the client family's needs, and feeling intimidated by the team were

negative experiences. The potential for learning, constructive feedback and the valuing of multiple perspectives were positive aspects for some respondents.

- It would appear that the experience of learning within the context of reflecting team practice is one that was perceived as enriching and enhancing on a number of levels, from skills development, knowledge of family dynamics and acceptance of diversity, to self-awareness and insight, and hence the capacity for reflexivity. In addition, confirmation of one's way of being in practice, i.e. authenticity, learning to manage anxiety and understanding personal family-of-origin resonances were significant themes.
- Findings on opinion of the influence of reflecting team practice upon theoretical approach was divided. Some respondents believed it to be minimal or even non-existent, while others saw it as more influential, albeit more or less positively. The theme of the benefit of eclectic practice was evident, as well as confirmation of what does and does not fit for the authenticity of practice by the respondents.
- The theme of differences in theoretical opinion being experienced as either enriching or prescriptive was evident from the responses. Again, team dynamics and composition, as well as hierarchy and the power differential were all factors that influence the perceptions and experiences of the respondents in participation in a reflecting team. The opportunity for learning and expanding theoretical knowledge was valued by some respondents.
- From the findings relating to ways in which reflecting team participation may enhance self-awareness, responses were fairly unequivocal in confirmation that reflecting team participation enhances self-awareness, the capacity for reflexivity, the development of the personal and professional self and understanding of one's own family-of-origin and family-of-procreation. Aspects such as team support and the value in learning from the post-session dialogue were also stressed.
- Reflecting team practice seemed to be viewed as an invaluable experience for both therapist and family, although some reservations are felt with regard to issues such as ethics, expense and practicality.

6.4.2.4 Perceptions, opinions and experiences relating to the self in family therapy practice

Personal self:

- Many of the respondents' descriptions of their family-of-origin revealed themes of loss. The death of parents, divorce, and the geographical dispersal of family members were themes shared in the reflections of the respondents.
- From the findings it can be seen that the respondents often played nurturing roles in their childhood families, roles not necessarily replicated in their family-of-procreation. Identified themes were: caretaker, 'parent', healer, and peacemaker. The capacity for self-awareness has allowed many of the respondents to let go of, or challenge roles that no longer work for them, or that contribute to a sense of immobility.
- Themes relating to the origin of the desire to become a healer included many of the issues explored by Goldberg (1986:53-60). Issues of loss, distress, family position and so on were evident in the reflections of the respondents.
- Different and similar themes were evoked in the exploration of the skills or abilities the respondents feel they have developed in their lives. It would appear that the respondents have been on a journey of skills training in helping throughout their lives. Important aspects mentioned were listening, empathy, life experience, confidence and the ability to engage with people on many levels.
- The development of skills that are both innate and acquired was stressed by the respondents. Ongoing learning and development were viewed as crucial.
- The findings reveal that experiences inviting entry into the field of family therapy were varied. Aspects mentioned were: family therapy training as an option provided by the organisation, or a requirement of internship or training; curiosity piqued by studies; personal loss or distress that resonated with a desire to improve family functioning on a wider scale, and, belief in the importance of the family as a foundation of society.
- The significant influences nurturing of an interest in family therapy were numerous, and included team facilitators at the organisation under study, lecturers, other

experiences of working with families that proved challenging, and once again, team colleagues and team composition.

- Aspects of the self that are brought to the family therapy context were viewed as important by the respondents. A number of themes were reflected on, including personal experiences, values and beliefs about families, respect for client self-determination, and professional integrity with regard to practice and theoretical orientation.
- From the findings it can be deduced that the use of self-disclosure requires enormous awareness of self, regarding many aspects, and that there are risks for clients that necessitate continued reflexivity and insight on the part of the therapist. The issue of not doing harm to client families was once again evident in the responses to the theme of self-disclosure.
- The most significant personal quality emphasised by most, if not all of the respondents was self-awareness. Such self-awareness is deemed necessary in many aspects, including one's own family dynamics and the appropriateness of self-disclosure. The importance of a congruent therapeutic style was mentioned, as well as confidence and taking a position of not-knowing.
- From the findings, certain challenging life experiences have given the respondents a wealth of empathic resources to use in their responses to client family issues, as well as the ability to facilitate choice and to provide a focus on family strengths. Experiences included the experience of loss through death, divorce and emigration, and family issues. The personal life experiences of the respondents impact not only on career choice, but also on the capacity for reflexivity and self-awareness, and thus contribute to their professional development.
- Family therapy may have the potential to impact on practitioners. This impact is however, experienced as more positive than negative, in that for many respondents, a new appreciation and value for their own families has developed. Less positive is the impact on personal health which requires ongoing management. Working with families has provided new insights into therapeutic work on a more general level, as well as enhancing the depth of understanding both personally and professionally.

- The importance of working with families as a system, even when the problem appears to be an individual one, was apparent from the findings.

Professional self:

- Findings on the career stories of the respondents reflected many aspects already covered in other themes. Again, issues of personal loss and the resolution of these was mentioned, the hope being to facilitate skills in order that client families are better able to cope with challenges and change. The theme of an element of personal dysfunction in own family-of-origin was explored by some respondents as part of their career story. The need for professional growth in working with families, and the personal belief of the importance of families in society were also mentioned as elements of the career story.
- The preferred way of being as a family therapist and the fit with the personal self revealed a strong theme of congruency for the respondents. The sense of being real, authentic and self-aware was apparent from the findings. In addition, being empathic, intuitive and non-expert were explored as preferred ways of being. For one respondent, reflecting team practice challenges, at times, her sense of authenticity in practice, because, in her view, the feedback to the family often lacks challenge.
- Regarding the theme of how the respondents hope client families will experience themselves during the encounter, many of the responses illuminated the wish for the session to be a safe space for client families to explore, and that the process will prove facilitative of change. The wish for a belief in growth and healing and the regaining of self-worth for families were alluded to. The manner of reflecting team practice proved difficult at times for one respondent, who believed it has the potential to impact negatively on the therapeutic alliance.
- With regard to awareness of professional role, the difference in responses seemed to lie in whether or not such awareness is more in the foreground of the therapist's perception. Some of the other respondents believed their professional role to be more to the forefront of their thinking, while for a few it takes on less significance during the actual therapeutic encounter. That is not to imply however, that professional aspects are forgotten. The non-expert role of facilitator was stressed in the findings.

- According to the findings, an important aspect raised by many of the respondents regarding the theme of beliefs about professional role upon the therapeutic encounter with the client family, was the issue of client's expectations regarding the role of the professional. The difficulty at times is the expectations of client families, which may impact on how the professional role is experienced and implemented. The client families' expectation of professional expertise seems at times to get in the way of their own self-determination and empowerment.
- Responses to the theme of client issues that may challenge or create discomfort showed variation, with some respondents stating specifically the issues that would prove challenging to them, and others being less certain, either through a lack of experience or the belief that they are able to work with most client populations encountered thus far. Particular areas of difficulty mentioned in the findings related to addiction, paedophilia, client resistance to change, and insensitivity to children's needs in the family therapy process.
- The development of the personal and professional self is a continuous and interrelated process and journey, demanding awareness of the many aspects that combine to form the self.

Burnout:

- According to the findings, work in the family therapy arena was experienced as very rewarding for some respondents, specifically the opportunity for learning and understanding on a systemic level. Some aspects relating to working with families that are less satisfying relate to the issue of the process becoming 'stuck', and aspects relating to authenticity and fit in terms of reflecting team practice.
- Most of the respondents indicated satisfaction with their personal life. Of the few who mentioned some less satisfactory elements, there was a sense of being able to keep separate, to some extent, the personal and the professional. Also evident however, was the link between the two aspects, and that they are interconnected with life satisfaction in general.
- The findings showed that family therapy practice, while rewarding, can also be experienced as a demanding and even draining process. The respondents seemed to

be aware of the risks involved, and undertake a number of activities that suggest that burnout prevention is part of everyday life.

- While the respondents may not have experienced burnout in full force, there was an awareness of the fact that it can occur, that aspects of their lives may challenge their ability to sustain the self, with the potential cost to self and hence authentic practice. The findings revealed that awareness of the importance of the need for self-care was high.

6.4.2.5 Opinions of family therapy practitioners on the future

- Findings revealed similar views regarding the future of family therapy, with a significant theme being the need for wider availability and accessibility, and a drawback relating to the expense in terms of human resources and cost.
- The importance and value placed on family therapy as an intervention was revealed in the findings relating to hopes for the future of family therapy practitioners, along with a wish to be able to continue to work with families in settings other than Family Life Centre in the future.
- A significant theme raised in the findings on recommendations to practitioners contemplating family therapy practice, was the issue of experience and preparation relating to family therapy intervention, with some respondents feeling that the lack of these aspects may be detrimental on a number of levels, i.e. to the experience of anxiety for interns and to the effectiveness of working with the client family. For other respondents however, the scope for learning and the enhancement of personal confidence as an outcome of reflecting team work was invaluable. The importance of augmenting theoretical knowledge was also stressed, while the issue of working in the evenings could prove to be a potential drawback.
- With regard to recommendations to Family Life Centre regarding family therapy practice, the findings explored themes relating to better preparation for the family prior to the initial session, improving the theoretical education and training provided at the Centre, the introduction of team supervision and, consideration of team composition. The issue of changes in composition and even team leadership so as to

facilitate alternative narratives in learning was suggested, and finally, a wish to improve the practicality and logistics of the facilities at the Centre.

- Further aspects touched on with regard to recommendations were a deeper contemplation of the needs of client families, and the significance of the experience of reflecting team practice in confirming the authenticity of the self in practice, albeit that the confirmation was that this was not the preferred method of practice for one respondent.

6.4.2.6 Limitations of the study

Some possible limitations to the study require consideration. These are:

- The respondents in the study are all personally known to the researcher, some more so than others, which may have influenced or biased their responses to the themes under exploration.
- The population of family therapy practitioners, specifically in the context of reflecting team practice, is fairly small, with this approach unique to the organisation under study (as far as the researcher is aware). Thus some of the findings may not be generalisable to other family therapy practitioners working in different settings, nor may they be replicated.

6.5 RECOMMENDATIONS

The field of family therapy is complex, with many approaches to intervention, as well as different methods of implementation with regard to the use of teams. The importance of theoretical and experiential training have been emphasised at length throughout this thesis, as has the crucial aspect of the self of the family therapy practitioner as an element in the development of a therapeutic alliance with client families that will be experienced as authentic to both.

From this research, certain recommendations will be made with regard to the empirical study.

6.5.1 Recommendations from the Study

Recommendations regarding theoretical training, experiential training, enhancing reflexivity and authenticity, and hypotheses for further research are discussed in the sections that follow.

6.5.1.1 Recommendations for theoretical training

The importance of theoretical training in family therapy is irrefutable. An understanding of the many schools of thought with regard to theory, as well as insight into the implications of epistemological shifts in the field, is fundamental to ethical and effective practice. This component of training has been insufficient at Family Life Centre, there being a tendency to rely on the theoretical training provided by the various universities attended by the practitioners. The extent and depth of training in family therapy varies considerably, hence practitioners begin family therapy practice at the organisation with significant differences regarding their knowledge of theory and intervention relating to working with families in distress.

It is the recommendation of the researcher that the theoretical component of training be an augmentation to that received in the under- and post-graduate training of the family therapy practitioners. The organisation under study already provides training in many spheres, for example: basic counselling skills training, advanced counselling training, prepare/enrich training for counsellors who work with premarital or married couples, divorce counselling training, mediation training and several other training courses. These training courses are available to the public and are aimed at social workers, psychologists and allied professionals (e.g. clergy, human resources personnel). Training courses for family therapy have **not** however, been part of the training program at Family Life Centre. The reason for this may be that only a small sector of practitioners at the

organisation is actually involved in the practice of family therapy. However, family therapy is practiced at the Centre by those who are interested in this aspect of intervention, and by interns/students who are required to participate in family therapy practice as part of their experiential training. The addition of family therapy training to the existing training program is recommended. Such a training course could be undertaken at the beginning of each year when the new students and interns start the practical component of their studies. In addition, the training course would also be available to any staff members or sessional workers at Family Life Centre who may be interested in becoming involved in this form of intervention. The interest of, and demand by, practitioners outside of the organisation may dictate whether such a training program is added to the existing schedule.

The enhancement of theoretical training for practitioners involved in family therapy intervention could also be achieved through the creation of regular study groups or reading groups which could be held at Family Life Centre.

A further option recommended by the researcher is self-study, a starting point being the literature review of this thesis which may pave the way to a clearer understanding of a theory or theories that is/are authentic to the self of the practitioner, and provide a stepping stone to a more in-depth study of a particular approach to family therapy practice.

In Chapter 4, the work of Treacher (1995) was explored with regard to the concept of user-friendly family therapy. A user-friendly approach to family therapy assumes that integrated models of therapy offer clients ways of working that are likely to suit them. No one model of counselling suits all possible clients. According to Treacher (1995:210), integrated models seem to be the way forward because they address the basic issue that clients may require different interventions at different times in their experience of therapy. From the findings it was concluded that many family therapy practitioners are in favour of an eclectic approach to family therapy. While the concept of integration (explored in Chapter 2 of the literature review) seems commendable, the practitioner is

required to have knowledge of the many theories in the field of family therapy before such integration could be contemplated, thus emphasising the necessity of enhanced theoretical training.

6.5.1.2 Recommendations for experiential training

Experiential training in the form of reflecting team practice has enormous value in terms of learning on many levels, from theoretical aspects to skills development, and on the capacity for reflexivity of the family therapy practitioners. Since this is the cornerstone of training at Family Life Centre, it should remain a central component of training, albeit that certain aspects require attention.

The experience of anxiety and the element of evaluation felt by many of the respondents, and reflected throughout many of the findings in this thesis, requires consideration of the manner in which experiential training is undertaken. A degree of evaluation of the students/interns is unavoidable, as feedback on their skills has to be given to their respective universities. In Chapter 3, Biever and Gardner (1995:49) posed the question of how one trains people within a model that suggests knowledge is negotiable. Trainees develop different understandings of a family and of the supervision process. The use of the reflecting team in a training setting is a way to minimise the contradictions inherent in the different models, and is consistent with social constructionist thinking. If reflecting team training is accepted as an enriching learning opportunity, the researcher recommends that the views, perspectives and understandings of trainees be given greater credence. A postmodern approach which focuses on understanding as central to experiential learning is more applicable and accessible in training situations, and is preferable to the didactic acquisition of skills that come with a modernist flavour of objectivity and 'correctness' (Du Toit, 2002:34).

Treacher (1995:216-217) emphasises the importance of training and professional development in influencing the attitudes of therapists. Family therapy training needs to be trainee-friendly, and based on ethically sound principles. Treacher believes that

authoritarian positions have permeated family therapy training programs, neglecting trainee perspectives and perpetuating a theme of neglecting family perspectives. The ethics of training should thus reflect respect for the skills and person of the therapist, and the creation of a training environment in which a relationship of trust can be built, a recommendation that resonates strongly for the researcher.

In Chapter 3, the views of White (1990:76-77) concerning the expectations of those involved in training and/or supervision were discussed. Such expectations are closely related to the beliefs held by both parties concerning the nature of the therapeutic encounter and training/supervision. If there is a match concerning the expectations of participants, a degree of comfort in the encounter will be achieved. However, such a match does not always occur and may result in conflict with resolution slanted in favour of the trainer or supervisor. White (1990:77) emphasises the importance of trainees being provided with knowledge about the ideas and practices that are embraced at the particular organisation where training will be undertaken, and on the nature and structure of the training context. Thus it is recommended that practitioners new to the organisation and/or the field of family therapy be fully informed as to the way in which family therapy is practiced, particularly the fact that reflecting team feedback follows the guidelines laid out by Tom Andersen (discussed in Chapter 3 of this thesis), and which reflect the principles and ethos of the family therapy department within Family Life Centre.

The importance of team composition, collaboration and power dynamics between reflecting team members requires further consideration. While challenge is important for professional growth, the perception of some respondents regarding the reflecting team experience as not being conducive to open and honest reflection is cause for concern. If one considers 'conditions of worth', as conceptualised by Rogers (in Merry, 2002:29), which are acquired through experiencing that one is acceptable only if one thinks, feels and behaves in ways that are positively valued by others, and experiences which are contrary to these are denied or distorted, creating a state of incongruence between self and experience - thus the person cannot be fully authentic. The self has the potential to be congruent with all experiences available to one's awareness, implying that the

authentic self does not need to distort or deny experiences. Perhaps it would be more facilitative of authenticity if the reflecting teams strived for a climate that is more accepting of difference, appreciative of multiple perspectives, a both/and position, and attentive listening to the views of others. It is of interest to the researcher that while we extend this way of being to the client families we serve, we perhaps fail to allow ourselves and our colleagues the same environment that promotes a safe place to explore and experience authenticity.

Team supervision was a recommendation expressed by several of the respondents in the findings. While a short post-session debriefing does take place after the family therapy session, it may be insufficient to explore the feelings, experiences and meanings that may resonate for the team participants. It is recommended that more attention and time be given to this meeting, encouraging fuller expression of issues that have yet to be resolved.

Also suggested by the practitioners was the issue of mixing the team, either for practice or discussion purposes. While the composition of the teams does change from time to time, the inclusion of interns at the beginning of each year means that most teams tend to remain fairly static over the year. For those practitioners involved for longer periods, the team will change a number of times. Perhaps the practicality of switching team members around may prove to be an unnecessary challenge. In addition, the question arises as to whether all of the team members would want to change, or only a few? However, discussion with all the team members may be called for, to gain insight into their needs and opinions on the issue. The researcher is of the opinion that a supervision meeting with all the practitioners may be beneficial from time to time. Ideas, opinions and experiences could be shared, possibly providing insight and enhancing reflexivity.

A further issue mentioned by a few respondents was the notion of encouraging the client family to question and explore the meanings of the team members' reflections. While the family are given the last part of the therapy session to reflect on what has been shared by the team, perhaps they could be briefed more thoroughly on their rights to question further what has been shared.

6.5.1.3 Recommendations for enhancing reflexivity and the authentic self

Family therapy practitioners are ethically obliged to enhance their knowledge of theory and self, and to create opportunities to gain experience, if they are to provide more effective services to client families in distress. The necessity of self-awareness on a personal and professional level is essential, and the self has a significant impact on the therapeutic relationship and thus on the therapeutic encounter. An undertaking into an exploration of self is a deeply personal journey, but one that is incumbent on every practitioner to embark upon. The way in which such a journey of exploration is undertaken cannot be prescribed since it is unique, but is also ongoing, throughout the career.

The recommendation of personal therapy is mentioned by various authors in Chapter 4 of the literature review and is one that resonates for the researcher. The experience of personal therapy to explore one's own issues and the potential these have to impact on the therapeutic encounter with the client family may be an important aspect of a journey into self-awareness.

The use of visualisation techniques such as those discussed by Aron and Siegel (1995:136-137) allow the practitioner to explore the idea of extra-therapeutic encounters with clients and their responses to these. Contemplation of such encounters is recommended, which may provide some inkling of issues pertaining to certain clients which would otherwise remain beneath the level of awareness.

A further possibility for self-exploration could be the keeping of a reflective journal, wherein the personal journey of the practitioner could be charted, and which may provide insights and meanings, and even patterns of thought that may require contemplation.

6.5.1.4 Recommendations for further research

The user-friendly approach to family therapy conceptualised by Treacher (1995:213) recognises the need for research to contribute to the development of theory and practice. The experience of families and their satisfaction with services must be evaluated and should form a crucial aspect of the assessment of any service. Unmonitored practice cannot be defended from an ethical standpoint. The voices and experiences of the recipients of family therapy need to be heard and explored in order to evaluate family therapy in general, and more specifically in a reflecting team setting such as is practiced at Family Life Centre. Insight into the needs and perceptions of the families utilising these services must be acquired, and their evaluations may result in improved service delivery.

A possible area for further study relating to this thesis could focus on how, if at all, practitioners' enhanced theoretical knowledge impacts on practice in the field of family therapy over time and with accumulated experience.

The necessity of 'fit', not only for the practitioner with regard to theory and self, but also the opinion expressed by many of the respondents relating to the client family in terms of their expectations of the family therapy process was discussed in the findings. An exploration of modernist, postmodern and integrated styles of intervention by family therapy practitioners could yield interesting data relating to their perceptions of aspects such as therapeutic encounter and therapeutic outcome.

The issue of reflecting team composition arose often in the findings. Further study regarding aspects relating to team composition, such as merging teams of social workers and psychologists, and the alternation of team leadership could be explored. The needs and expectations of reflecting team participants is an area that may be explored productively.

Many of the respondents expressed the wish to continue with family therapy in their private practice at some point in the future. An interesting area for research could be a comparison of family therapy practitioners working with families in a reflecting team and in private practice, the latter most likely without the use of a reflecting team.

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ANNEXURE A:

Permission for Research: Family Life Centre

ANNEXURE B:

Informed Consent Letter: Family Therapy Practitioners

INFORMED CONSENT

PARTICIPANT'S NAME……. DATE……...

PRINCIPAL INVESTIGATOR
Sue Cook
University of Pretoria

1. Title of Study:

An epistemological journey in search of reflexivity and the authentic self: family therapy theory and intervention.

2. Purpose of Study:

The purpose of the study is to explore the implications of epistemological shifts in the field of family therapy on the capacity for reflexivity and the development of an authentic self in practice.

3. Procedures:

I will be asked to participate in a face-to-face interview to respond to questions and themes relating to the phenomenon of epistemological shifts in the field of family therapy, theoretical and experiential training, experience of participation in a reflecting team, exploration of fit between theory and self, awareness of self and personal paradigm, and capacity for reflexivity. The interview will take place at my convenience, and the duration will be 1-2 hours. Should a further interview be deemed necessary, this will also be at my convenience and for the same duration.

4. Risks/discomfort:

There are no known risks or discomfort associated with the project. Should I experience fatigue or stress during the interview I will be given as many breaks as I feel necessary during the interview session. Should the need for debriefing arise, I may request a debriefing interview to be conducted at Family Life Centre.

5. Benefits:

I understand that there are no known direct benefits to me for participation in the study. However the results of the study may help family therapy practitioners to gain a better understanding of the opinions, perceptions and experiences of other practitioners with regard to the phenomenon of epistemological shifts in the field and the importance of reflexivity for authentic practice.

6. Participant's Rights:

I may withdraw from participating in the study at any time.

7. Confidentiality:

The results of the study may be published in professional journals or presented at professional conferences, but my identity will not be revealed unless required by law.

I understand my rights as a research subject, and I voluntarily consent to participation in the study. I understand what the study is about, and how and why it is being undertaken.

……. …….
Signature of subject Date

……
Signature of investigator

ANNEXURE C:

Interview Schedule

INTERVIEW SCHEDULE

FAMILY THERAPY PRACTITIONERS: FAMILY LIFE CENTRE

1. BIOGRAPHIC DETAILS

1.1 Gender:

1.2 Age:

1.3 Present Marital Status:

1.4 Tertiary education (including degree in progress, if applicable):

1.5 University/universities from which degree/degrees was/were obtained:

1.6 Position held at Family Life Centre: (i.e. intern, sessional worker, staff member):

1.7 Level of experience as a family therapy practitioner:

1.8 Counselling history (professional and non-professional, if applicable):

1.9 Other work experience:

1.10 Any further comments:

2. PERCEPTIONS, OPINIONS AND EXPERIENCES RELATING TO FAMILY THERAPY THEORY AND INTERVENTION

2.1 **Family Therapy Theory**

2.1.1 Opinion, if any, regarding the epistemological shift that has taken place in the field of family therapy over the past decade.

2.1.2 Theoretical approach/approaches used by respondent in the practice of family therapy.

2.1.3 Perceptions regarding the initial encounter with your chosen approach/approaches.

2.1.4 The way you chose your particular approach/approaches to family therapy practice.

2.1.5 The ways your chosen theoretical approach influences your personal values and/or beliefs.

2.1.6 The ways your personal values and/or beliefs influence your chosen theoretical approach.

2.1.7 The impact of your chosen theoretical approach on your personal and professional life.

2.1.8 The philosophy of your chosen theoretical approach and the fit with your preferences as a person and as a family therapy practitioner.

2.1.9 The ways, if at all, your approach to family therapy has changed since entering the field of family therapy.

2.1.10 The type of theoretical approach/approaches that does/do **not** fit with your preferences as a person and as a family therapist.

2.1.11 The way you would have been as a family therapist and as a person, if you had **not** come across your chosen theoretical approach/approaches.

2.1.12 Any further comments:

2.2 **Intervention**

2.2.1 The ways your interventions are consistent with your chosen theoretical approach.

2.2.2 The ways your chosen approach contributes to a positive therapeutic relationship.

2.2.3 The ways you as a family therapist contribute to a positive therapeutic relationship.

2.2.4 The ways of relating to client families you have found to be most helpful.

2.2.5 Your values and beliefs about change during family therapy intervention.

2.2.6 The ways this personal belief about change influences your intervention with the client family.

2.2.7 The messages your interventions might send to the client family.

2.2.8 The ways, if at all, your beliefs about families have changed since entering the field of family therapy.

2.2.9 The extent to which your chosen theoretical approach has challenged your views, beliefs and attitudes with regard to intervention and the practice of family therapy.

2.2.10 The importance of being aware of your chosen theoretical approach in intervention and the practice of family therapy.

2.2.11 Any further comments:

3. PERCEPTIONS, OPINIONS AND EXPERIENCES RELATING TO PARTICIPATION IN A REFLECTING TEAM

3.1 Your knowledge of reflecting team practice in family therapy prior to participation.

3.2 Your expectations of reflecting team practice prior to participation.

3.3 Describe your experience of being an 'observer' of the client family.

3.4 Changes in your experience of being an observer over time.

3.5 Describe your experience of being 'observed' by the client family.

3.6 Changes in your experience of being observed by the client family over time.

3.7 Describe your general impression of participation in a reflecting team process.

3.8 The feelings typically experienced during a family therapy session, i.e. about the family, the family therapist, yourself.

3.9 Describe any incidents that may have significantly influenced you, either positively or negatively, during participation in a reflecting team.

3.10 Describe your learning from the experience of participation in a reflecting team (i.e. about your skills, knowledge, self).

3.11 Ways in which participation in a reflecting team may have influenced your choice of theoretical approach.

3.12 Feelings when fellow reflecting team members evidence different theoretical approaches in family therapy practice.

3.13 Ways, if any, in which participation in a reflecting team has fostered a higher self-awareness of yourself on both a personal and a professional level.

3.14 Any further comments:

4. PERCEPTIONS, OPINIONS AND EXPERIENCES RELATING TO THE SELF IN FAMILY THERAPY PRACTICE

4.1 **Personal Self**

4.1.1 Draw, if willing, or describe a genogram of your family-of-origin and family-of-procreation (if applicable).

4.1.2 Your role in your family-of-origin/family-of-procreation and feelings regarding that role.

4.1.3 Origin of your desire to help others.

4.1.4 Skills or abilities relating to helping others that you have developed in your life.

4.1.5 Describe the importance to you of being able to develop these abilities.

4.1.6 The experiences in your life that invited you to enter the field of family therapy.

4.1.7 The significant influences that nurtured your interest in the field of family therapy.

4.1.8 The aspects of your self that you believe you bring to the family therapy context.

4.1.9 Your awareness of your personal responses during the therapeutic encounter.

4.1.10 Knowledge of when/when not to use your personal responses to facilitate the family therapy process.

4.1.11 The personal qualities you believe are critical to one's use of self within the family therapy context.

4.1.12 Discuss, if applicable, the way a personal crisis in the course of your professional career was dealt with, as well as the way your achieved resolution. Any new outcomes or conclusions that become available and contributed to your family counselling career.

4.1.13 Discuss, if at all, the way family therapy practice may have affected your personal life.

4.1.14 Any further comments:

4.2 **Professional Self**

4.2.1 Write, if willing, or describe your career story (i.e. personal experiences that have contributed to your decision to be a family therapy practitioner, the resolution and the outcome that may have contributed to shaping your counselling career).

4.2.2 Your preferred ways of being as a person and as a family therapist.

4.2.3 Your experience of the fit between your preferred ways of being as a person and as a family therapy practitioner.

4.2.4 Your hopes about how families experience themselves when they are with you.

4.2.5 Awareness of your professional role during a therapeutic encounter with a client family.

4.2.6 Beliefs about the impact of your professional role on the client family.

4.2.7 Awareness of client issues that challenge you or contribute to feelings of discomfort.

4.2.8 Any further comments:

4.3 **Burnout**

4.3.1 Describe your level of satisfaction (or not) with your work as a family therapist at Family Life Centre.

4.3.2 Describe your level of satisfaction (or not) with your personal life.

4.3.3 Describe how you sustain yourself in your career as a family therapy practitioner.

4.3.4 Challenges to your ability to sustain yourself.

4.3.5 Any further comments:

5. OPINIONS OF FAMILY THERAPY PRACTITIONERS ON THE FUTURE

5.1 Hopes for the future of family therapy.

5.2 Hopes for your future as a family therapist.

5.3 Recommendations you would like to make for practitioners considering participation in the field of family therapy at Family Life Centre.

5.4 Recommendations you would like to make to Family Life Centre with regard to the practice of family therapy.

5.5 Any further comments: