THE LEARNING AND TEACHING OF SYSTEMIC THERAPY – AN ACTION RESEARCH APPROACH

by

WILLEM P LOUW

submitted in partial fulfilment of the requirements for the degree of

MASTER OF ARTS IN CLINICAL PSYCHOLOGY

at the

UNIVERSITY OF SOUTH AFRICA

SUPERVISOR: PROF G RADEMEYER

APRIL 2000
nothing more can be attempted than to establish the beginning and the direction of an infinitely long road. The pretension of any systematic and definite completeness would be, at least, a self-illusion. Perfection can here be obtained by the individual student only in the subjective sense that he communicates everything he has been able to see.

- Georg Simmel
Castaneda, *The Teachings of Don Juan*

For me there is only the travelling on paths that have heart, on any path that may have heart. There I travel, and the only worthwhile challenge is to traverse its full length. And there I travel looking, looking, breathlessly.

- Don Juan
Castaneda, *The Teachings of Don Juan*

Stop this day and night with me and you shall possess the origin of all poems,
You shall possess the good of the earth and sun, (there are millions of suns left),
You shall no longer take things at second or third hand, nor look through the eyes of the dead, nor feed on the spectres in books,
You shall not look through my eyes either, nor take things from me,
You shall listen to all sides and filter them from your self.

- Walt Whitman
*Leaves of Grass*
ABSTRACT

The training of psychotherapists not only determines what new therapists learn about the practice of therapy, but influences significantly their identity and the development of a professional self. This dissertation explores the professional development of a trainee therapist, taking into consideration the training context and training approach, the trainee’s unique training needs and the influence of own interactional style. The study was undertaken from an action research perspective, therefore emphasising solving a problem in the field and feeding this information back into the system during the course of the research project. The researcher describes how the training context (in this case, the Agape Healing Community in Mamelodi, South Africa), the training approach (systemic family therapy), and his personal style shaped his professional sense of self. He found however, that it was the process of action research which encouraged movement from feelings of inadequacy to competence in his professional development.

Key Terms

Action research, systemic training, professional development, Agape Healing Community, supervision, trainee psychotherapist, postmodernism, therapist helplessness, self-reflexiveness.
ACKNOWLEDGEMENTS

To my mother, Lenette, for understanding when I said “ek moet kan” and for accepting me with such warmth in whatever direction I grow, and

To my father, Adriaan, who is forever showing me that there is always another way of looking at this crazy world and for shaping my critical self:

You have been more instrumental in my becoming a healer and psychotherapist than even I realised before undertaking this research.

To Stan, who brought me into contact with the healing spirit and made a space for me to sense the sacred:

From our countless conversations on the nature of psychotherapy and shared experiences of holy moments, I have received an archetypal image of an ethical healer who, guided by respect, creates a context for both the client’s and his own healing to take place. I thank you for this incredible gift.

To Gert, who patiently endured my helplessness and believed to the end that I had something worthwhile to contribute:

Your extraordinary personal wisdom and experience and your confidence in action research have been the guiding light of this research project and instrumental in the healing of my professional self. You have instilled in me an immense appreciation for action research and, with your tireless comments and suggestions, taught me to recognise academic and scientific professionalism. I thank you for the profound gift of teaching me the essence of research.

To my wife, Penny, who often understood better than I the ideas that I wanted to convey and who made sure that the rest of the world would also be able to:

For making me believe that this document would also have an end, for ruthlessly correcting my grammar and editing the text, for always coming up with the right word, for hot suppers, cool drinks and whatever it took to help me finish – thank you! You are the wind beneath my wings, you make my journey a worthwhile one.
ABSTRACT

CHAPTER 1  OVERVIEW .............................................. 1

CHAPTER 2  JOURNEY INTO THE UNKNOWN ........... 4
  Getting Lost .............................................. 7

CHAPTER 3  A COURSE IN SURVIVAL ....................... 11

CHAPTER 4  SURVEYING THE TERRAIN ..................... 16

CHAPTER 5  GETTING HOLD OF A MAP .................... 24
  The Inner Compass ...................................... 27

CHAPTER 6  CONSULTING A MAP ......................... 30
  The Map is not the Territory .......................... 31
  Losing Momentum ......................................... 38

CHAPTER 7  A CHANGE OF SCENERY ....................... 39
  Difficult Terrain .......................................... 40
  Making Headway .......................................... 45
  A Growing Sense of Direction .......................... 54

CHAPTER 8  DEBRIEFING ........................................ 56
  Discussion .................................................. 58

EPILOGUE ....................................................... 64

REFERENCES ................................................... 66
CHAPTER 1

OVERVIEW

The gap between a new MA (Clinical Psychology) student and a qualified psychotherapist is a formidable one. During this time the fledgling therapist must not only learn the skills and techniques essential to the profession, but must adopt an entirely new identity as a professional and as a healer. This is a journey on which trainees are closely accompanied by their trainers, usually university supervisors and lecturers, and is one which, in attempting to examine and design training contexts, has been the focus of much research.

The experiences I am about to describe happened over a span of three years and represent my struggle to make sense of what it is to be a psychotherapist. I interpreted this struggle as encompassing the ideas of what it is to do therapy (skills) and what it means to be a psychotherapist (identity). This difficulty in defining myself in the therapeutic context presented by the clinic where I trained was present on the first day I ventured into the praxis of psychotherapy and is still relevant to me today. It was an issue which seemed to be intertwined both with the characteristics of the training context and with my personal interactional style.

This dissertation is a report of my efforts to make sense of the feelings
of uncertainty and inadequacy I experienced during my training as a therapist. In so doing, it also comments on the training process and systemic models of training psychotherapists. Making sense of these feelings became necessary when they continued to instill a sense of helplessness in me. I sought answers both to my client's questions and to my own regarding my role and identity as a therapist. However, all such attempts failed until I made this issue a research question and started to apply systematic problem-solving strategies. These events coincided with my introduction to action research as a way of solving problems experienced in everyday situations in a relatively short space of time.

Action research gave me the opportunity to take charge of my own professional development — and resulted in unexpected gains and insights. Before embarking on this research it felt as if my development as a therapist was stuck. I felt lost in therapy — I felt that I did not know what to do in the session with the client. The fundamental question that kept haunting me was: "What is therapy?" My attempts at explaining this worrisome experience to my supervisor were met with reassurance that my feelings were legitimate and normal, and I was unable to convince him otherwise. By refusing to solve my problem, my supervisor forced me into the decision to take action myself. This action took the form of an action research question which evolved into the topic of this dissertation.

Through this research, I came to the conclusion that the nature of the systemic training context and especially the clinic where I did my practicals
contributed significantly to my experiences of growth or stuckness as a therapist. Another factor which I identified as playing a vital role in my stuckness was my own style of relating to others (interpersonal style). My argument stresses the importance of considering the nature of the training situation and the demands it makes on trainee therapists in the light of their own interactional style.

Although this dissertation, in the spirit of action research, focuses on my personal struggle and the steps I took to resolve this, it seems likely that the dilemma of developing a professional self in a particular training context is one faced by many trainee therapists. This dissertation is therefore not only a report on my scientific research, but also an example of how action research can be used to solve problems experienced by therapists in their professional development.

Action research does not aim to build or contribute to theory. This dissertation, therefore, focuses on how I researched and eventually solved my training dilemma in a scientific and ethically responsible way. What follows is an account of the way I thought and acted with respect to my struggle in therapy, how this understanding evolved and how I grew as a therapist over a period of three years. I guess I could call this dissertation a formal discussion of my journey as psychotherapist.
CHAPTER 2

JOURNEY INTO THE UNKNOWN

I started my training as a psychotherapist with definite expectations. I expected to learn how to do therapy and to experience a steady growth in therapeutic proficiency (with an accompanying confidence about my identity as a psychotherapist). I wanted to make a difference to those who sought my help. What I certainly did not expect was that the learning process would become increasingly difficult and that I would remain dissatisfied with my progress for the better part of the training programme.

It all started at the University of South Africa in February 1997. I had been selected for the Master’s Degree in Clinical Psychology under the direct supervision of Professor Stan Lifschitz1. As part of my training I was inter alia required to work in his community psychotherapy clinic on Wednesdays from nine in the morning till four in the afternoon. This clinic was called the Agape Healing Community and was situated in the township of Mamelodi, east of Pretoria.

My training involved weekly lectures on the art and theory of psychotherapy and was based on a systemic epistemology. I followed, understood and developed an affinity for most of the theory during these two

1 Whom I shall henceforth refer to as Stan
years. But no matter how much I liked a particular theory, I did not find it legitimised at Agape. Theories of psychotherapy were considered redundant and even harmful there; rather, I was continually reminded that psychotherapy was but a member of the class of healing work. This made intuitive sense to me and I could appreciate the significance of such an approach. I felt tremendously privileged to be trained in this environment.

However, given my appreciation for this philosophy, there was still a part of me that held fast to the idea that I was in the process of becoming a psychotherapist and that I had two years in which to learn this “trade”. I discussed these thoughts with Stan, who explained the dilemma I experienced as the struggle between the Sacred and the Secular. He said that healing falls into the arena of the Sacred and that theories of psychotherapy belong to the domain of the Secular. He felt that in my development as a psychotherapist I would have ample exposure to the secular, and so his concern was rather my exposure to the sacred part, which is a side of psychotherapy that cannot be experienced in a book. My trust in Stan was immense, I intuitively agreed with most of what he said; but a part of me remained uncomfortable. I could not identify this discomfort; it was simply a vague uneasiness that I found hard to express. It is this discomfort, I believe, that played the biggest part in the evolution of my development as a psychotherapist.

In retrospect, the discomfort I experienced can best be described as feelings of uncertainty and frustration. These feelings initially centred around what to do in therapy. There was no publication of the approach at Agape.
The learning and teaching of systemic therapy - An action research approach

that I could study. It also felt as if the practical training which I received there was divorced from the theoretical seminars offered at the university.

The one thing Stan did prescribe was reflection: religious reflection on each case and on the activities of the clinic as a whole. He would repeatedly remind us to document our experiences and our sense of what had transpired each day. What exactly this "sense" was remained obscure to me, yet I felt as if I was supposed to know what it meant. The result was that I wrote down my impressions without knowing what to do with them.

Stan was adamant about the notions of "community" and "connectedness". The Agape philosophy required one to find a way to connect with clients. It was also important to introduce clients to the other members of Agape and make them feel a part of it. To connect with clients and to "create community" for them was regarded as healing. My impression was that psychotherapy was regarded as a limited aspect of healing since it was defined as something that happened only in the relationship between client and therapist. The concept of healing incorporated psychotherapy; however, interactions with the client before and after therapy were considered equally important. This was especially significant in the Agape context, where clients and therapists spent the whole day together but dedicated only an hour or two of the day to conventional psychotherapy. The Agape philosophy further suggested that healing occurs in many contexts besides psychotherapy. As a healer, my mission was to connect clients not only with the community at Agape, but also with the community from which
they came. Problems were conceptualised as originating from and perpetuated by the clients' disconnectedness from their own communities.

Getting Lost

Being defined as a healer appealed to me but did not dispel the feelings of uneasiness and uncertainty which arose from my attempts to do therapy. At first I thought that such feelings were normal and to be expected. However, when they persisted and grew stronger, the urge to do something about the situation mounted. How to produce movement in therapy was the question that began to haunt me.

Defining therapy as "giving voice to the unspoken" or "touching the client behind the mask" confused me. I did not know what this meant or what it felt like. It was impossible for me to tell whether I had in fact touched clients behind their mask or whether I had managed to give voice to the unspoken aspects of their life.

Being unable to make sense of my situation left me with the feeling that I did not know what I was supposed to do. Therapy turned out to be nothing more than a respectful conversation. The best I could achieve whilst talking to clients was to inquire about their difficulties. I remained at a loss about what to do with the information that I had so diligently acquired.

My usual way of dealing with these feelings of incompetence was to consult Stan and confess that I did not know what I was doing. The
platform for our discussions was usually a case which I sought advice on. I would go for supervision and declare myself completely at a loss about what to do, hoping that Stan would walk me through the solution step by step. Instead we would launch into a discussion about therapy – that it was not about doing something but about being in specific way. He would assure me that it was normal to feel uncertain about what to do, and that feeling at a loss was the very emotion that would help me decide which route to take. The struggle to make sense of any therapeutic reality, Stan told me, was what would inform my work; that which clients evoked in me would provide me with all I needed to become unstuck. And when, after all of this, I still felt incompetent, I would truly be in a position to empathise with my client – who in all probability felt exactly the same way.

Predictably, I would leave the supervision session confused. I would feel that I had understood everything Stan was talking about, yet I would not have the faintest clue as to how this knowledge was going to improve my situation. Nonetheless, Stan had succeeded in relieving my fear that I was unfit to be a psychotherapist. According to him, my struggle was, in fact, the very thing that qualified me to be a healer.

Cul de Sac

This pattern continued for the duration of my first year at Agape. In spite of this, I trusted Stan’s judgement implicitly. I believed that my expectations of myself were too high and that my problem lay with my own prejudices about therapy. I realised that I had entered training with the
desire to be helpful to clients; to enable them to leave the session feeling better than before; and to be able to tell that something was accomplished during therapy. Stan's advice suggested that this type of thinking was counterproductive. I needed to let go of it. I was doing fine and did not need to change anything. I was exactly where I should be. Unfortunately, I could not reconcile myself to these beliefs, and somehow the nagging feeling that all was not well remained.

I was starting to feel annoyed with the experience of repeatedly ending up lost in therapy. In addition, it began to affect the way I saw myself. I realised I was caught in a paradox: I felt incompetent yet was assured that I was not.

I suspect that Stan also started to feel pestered by the demon of incompetence, and the situation finally came to a head in April 1998 when he admitted that we were stuck. Since I also needed to get started on research for my dissertation, we agreed that it would probably not be wise for Stan to take on the additional role of dissertation supervisor. He suggested that I speak to Professor Gert Rademeyer\(^2\) in this regard and, since I had for some time already considered involving Gert in my dissertation, I agreed. Shortly after Stan and I decided that a different dissertation supervisor would be beneficial to me, I made an appointment with Gert. He agreed to

\(^2\) Whom I shall henceforth refer to as Gert
supervise my dissertation research and requested that I write a report on my research so far, describing the issue which concerned me.

In my report to Gert I described my feelings of dissatisfaction at Agape. I felt incompetent as a therapist since I did not feel that I could make a difference to my clients in the way that I wanted to. I felt that my development as a psychotherapist was stuck. I furthermore felt helpless to remedy this situation.

After reading my report, Gert suggested that my dilemma lent itself beautifully to an action research project, and proposed that we start immediately.
Early in 1998, Gert presented a seminar on Action Research as part of the Master's programme. He believed that this approach was of fundamental importance to the business of psychotherapy. I felt especially drawn to this type of research since it was geared toward change rather than understanding (Rademeyer, 1999a). It was all about solving problems encountered in the process of living – like those which therapists are confronted with on a daily basis. Apart from its practical appeal, action research also impressed me because of its proven track record and its fit with the philosophy of constructivism which the Unisa programme ascribed to.

During the 1970s, educationists started to voice their dissatisfaction with the prescriptive application of educational theory. Teachers argued that established educational practice often failed them when they were confronted with unique and problematic classroom situations. They therefore expressed a need for theory to be moved closer to practice rather than the other way around (Carr & Kemmis, 1986). Accordingly, their professional development needed to be approached differently. A “bottom-up” strategy was preferred to a “top-down” one. The rediscovery of Lewin’s (1946) ideas on the relationship between science and social change showed them a way of achieving their objective. Lewin argued that drastic measures were
necessary in dealing with the social crises caused by World War II. An "ivory tower" approach to the production of knowledge could no longer be afforded. Scientists needed to involve themselves at the "coal-face" and learn through experience. He called this approach "Action Research" and suggested that it be carried out according to a simple four step model (cf. Figure 3.1).

REFLECTING

OBSERVING

PLANNING

ACTING

Figure 3.1. Lewin's problem-solving model (McNiff, 1988)

Action research rapidly gained acceptance during the post-war years and was particularly influential in expanding our knowledge of group dynamics and organisational behaviour (Marrow, 1969). It also had a significant impact on educational research and training (Corey, 1953). However, despite its early popularity, the approach eventually fell into disrepute because it was considered as less rigorous and too limited in scope (McKay, 1992). Fortunately this situation has since changed. A new appreciation for
Lewin's ideas has been brought about by developments in the field of epistemology, notably the rise of constructivism (Gergen, 1985; Watzlawick, 1984).

Reviewing the development and current practice of action research led Peters and Robinson (1984) to distinguish between two versions of the approach – a weaker one and a stronger one. These authors rejected (1) the separation of the knower from the object of knowledge, (2) the "neutrality" of positivist research, and (3) the independent role of the "expert observer". What this basically means is that the idea of objectivity is considered to be fundamentally flawed. All our descriptions and interpretations are self-referential in nature (Keeney, 1983). Reality is not discovered but constructed through social interaction (Real, 1990). Furthermore, because of the "infinite number of constructions that might be made ... there are multiple realities" (Lincoln & Guba, 1985, p.84). Peters and Robinson (1984) therefore rightly conclude that

an epistemology [which] stresses understanding of the world [which] is both social and constitutive [implies that] social actors who have created their own histories can also reflect upon themselves and transform their reality. (p.121)

This exactly the point of view which educationalists eventually adopted and which allowed them to effect significant school reform in countries like England and Australia. In doing so, they reaped major benefits like personal
and professional growth, a sense of empowerment and a release of creativity (McKay, 1992).

Given my particular training impasse, these were precisely the kinds of experiences I was looking for. Paraphrasing Carr and Kemmis (1986), I was ready to “conduct a self-reflective inquiry into the clinical situation in order to improve my own therapeutic practice by deepening my understanding of it as well as the context in which it took place” (p.162). To this end I would be applying the Lewinian model by completing the cycle of problem-solving steps as often as necessary. This was not going to involve complicated procedures, but it would require me to be mindful and thorough. Moreover, the timely and extensive documentation of all aspects of the process was absolutely essential (Kemmis & McTaggart, 1982; McNiff, 1988). Without it I would be hard put to show that I had followed a system of disciplined inquiry (McNiff, 1988). Given the value-driven nature of this kind of project (Rademeyer, 1999a), it was imperative that I should “examine my own patterns of organising experience [and] expose them for scrutiny [by the academic fraternity]” (Atkinson & Heath, 1990, p.12).

Finally, I realised that the unique and individual character of my research would not allow for either replication or generalisation. However, this need not detract from its potential value. The degree to which my experience would resonate with others was of much greater importance. One proviso remained however: I needed to render a trustworthy account of my experience (Lincoln & Guba, 1985). By following these precepts I would in
effect be taking charge of my own professional development and hopefully grow into a truly reflective practitioner (Schön, 1992).
CHAPTER 4

SURVEYING THE TERRAIN

From the outset, my meetings with Gert were characterised by action: we arranged to meet twice weekly with specific assignments to be completed for each meeting. My need for structure and direction was met and I felt immensely relieved. My first task was to write up and code verbatim accounts of problematic conversations that I had conducted with clients. This was done in order to identify and characterise the typical communication patterns that occurred between myself and my clients. The object of the exercise was to establish exactly what transpired during therapeutic encounters. Bales’ (1970) system of Interaction Process Analysis was used for this purpose (see Table 4.1).

Table 4.1
Categories of Communication

<table>
<thead>
<tr>
<th></th>
<th>SEEMS FRIENDLY</th>
<th>DISPOSITION</th>
<th>SEEMS UNFRIENDLY</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>DRAMATISES</td>
<td>EMOTION</td>
<td>SHOWS TENSION</td>
</tr>
<tr>
<td>2</td>
<td>AGREES</td>
<td>AGREEMENT</td>
<td>DISAGREES</td>
</tr>
<tr>
<td>3</td>
<td>GIVES SUGGESTION</td>
<td>SUGGESTION</td>
<td>ASKS FOR SUGGESTION</td>
</tr>
<tr>
<td>4</td>
<td>GIVES OPINION</td>
<td>OPINION</td>
<td>ASKS FOR OPINION</td>
</tr>
<tr>
<td>5</td>
<td>GIVES INFORMATION</td>
<td>INFORMATION</td>
<td>ASKS FOR INFORMATION</td>
</tr>
</tbody>
</table>
Through this process, I discovered that I typically asked closed questions, namely questions that only required monosyllabic answers like 'yes' or 'no'. This is illustrated by the following excerpt from a conversation with Sandra (10-06-1998).

**T20** Does Mxolisi know?

**C20** No.

**T21** So he will find out in court?

**C21** Yes.

**T22** Who knows about your fear?

**C22** My mother and father.

**T23** Do they understand that you are scared?

**C23** Yes.

**T29** Do you still get nightmares?

**C29** No.

**T30** And your schoolwork is going fine?

**C30** Fine.
T31  Do you still see Catherine? [Client’s teacher]
C31  Everyday.

T32  Does she ask you what you do here at Agape?
C32  Yes.

I found that I not only dictated the course of the conversation but I also tended to ask irrelevant questions. This is illustrated by another excerpt from the same conversation.

T1  So, how’s life?
C1  Okay.

T2  How’s school?
C2  School is perfect.

T3  Uh-huh.
C3  Say something Willem.

T4  Do you use taxis often?
C4  Yes.

-----------------------------

T33  What do you tell her?
C33 I sometimes go to other places and then tell her Agape sent me there.

T34 Do you know why Abraham is walking like that - what happened that made him cripple?
C34 I always thought he was hit by a car.

T35 No, Abraham was drinking with his friend outside a shebeen when he insulted his drunk friend, who then beat him with a sjambok. Abraham woke up in hospital and since that day he walks like that. Sometimes people can really hurt us very badly and some of the wounds never heal.
C35 There is a little girl at school - she is in Grade One - who told me that her uncle loves her and then gives her some bucks for it.

T36 Sheesh!
C36 Another girl was raped by five boys in Grade One. The boys say that the other girl, who is loved by her uncle, told them what to do.

T37 When the little girl told you that, was she crying?
C37 She was crying.

Upon reflection I decided that this happened when I did not know how to respond to the client's answers. When under pressure I tended to ask just
any kind of question in order to keep the conversation going. It also became apparent that I was lacking a clear frame of reference.

Writing up the conversations was useful: it provided me with a structured way of analysing my work. Getting down to specifics facilitated my thinking about what I was doing. Granted, this did not really suggest how I could improve, but I was becoming aware of my characteristic pattern of interaction with clients.

Tracking

At this point Gert suggested that allowing clients to talk about what they wanted to was more important than anything else. It was also the surest way of keeping the conversation going. He explained the concept of “tracking” (Minuchin, 1974) and encouraged me to experiment with it at the earliest opportunity.

One such opportunity presented itself during my contact with Isaac (24-06-1998). The following excerpt shows how I was able to ‘stay with the client’. I initially assumed that I knew what Isaac meant and did not encourage him to expand on what he was telling me (C19-21). Later, however, I made an attempt to enquire further into what he was trying to say.

C19 ...... you see? Now the court ... I have dropped the case. I

---

3 Conducting a reasonable conversation is an essential condition for exploring the client-therapist relationship.
say, no man, it is not like this. Let us drop the case, you see?
Now that man is outside now, but that woman, if she sees me now, she is still angry about that; she does not want me to see
the child, I don't know what is going on.

T19 Yes.

C20 You know, if you have a child with a woman, you can't sleep well. Every time you see children, you think of your child, you long for your child. If he grows up, that man is not going to look after him.

T20 Yes.

C21 He is going to look after his own children, my child is going to suffer.

T21 Yes (nods). Yes.

---

T29 Is Sharon still mad at you?

C29 Yes, she is still mad at me, I don't know why. Because if she wasn't angry, she would have sent the child to come and visit me. They must teach that child about me, so that she can say: “That is my father, I will go and visit him this weekend”. Sometimes she should stay with me, other times with her mother, as she grows up, as long as she is familiar with her dad's place.
What interested me about the process was that I had been able to obtain a wealth of information from the client. However, I had several concerns about the effects of tracking. For example, (1) I found it difficult to end the session (which carried on for two hours), and (2) I was uncertain about what
to do with all the information that I had obtained. Was it important to do anything with the information, or was the way we talked more important than anything else?

Gert found it hard to believe that I was still at a loss when dealing with clients – especially since I had been in training for almost eighteen months! What could account for such a state of affairs? Gert’s opinion was that there are basically three reasons why trainees experience difficulty in working effectively with clients, namely:

(1) a poor grasp of the theory of psychotherapy
(2) inadequate skill in applying such theory
(3) the interference of personal issues (Kantor & Andreozzi, 1985) with the implementation of a particular therapeutic orientation.

Given my confusion regarding the Agape approach and the fact that muddling through was detrimental to my sense of self, Gert deemed it imperative that I start using a simple and more straightforward approach to therapy.
CHAPTER 5

GETTING HOLD OF A MAP

Since I was greatly relieved at the structured approach which we were following in analysing my particular situation, it seemed logical that a similar approach to therapy would suit me best. Consequently, I decided to employ the Brief Therapy Model of the Mental Research Institute\(^4\) (Watzlawick, Weakland & Fisch, 1974), which I had been introduced to during the academic component of the MA course.

It is important to note that following this approach should not necessarily be regarded as the solution to my research problem. On the contrary, it merely represented a further attempt to investigate my situation. Kurt Lewin, the father of Action Research, maintained that the surest way to understand something was to try and change it (Lewin, 1946).

It goes without saying that carefully monitoring the effects of applying the MRI model was of utmost importance. I did this by documenting subsequent conversations with clients in the following way. After describing the course of the entire conversation in my own words, I would (1) identify the pattern of interaction which evolved between myself and the client

\(^4\) Which I will henceforth refer to as the MRI model.
(2) indicate those aspects of my contribution with which I felt satisfied or dissatisfied

(3) reflect on the implications of this

Despite my best intentions I sadly found myself doing "more of the same" during the next few interviews. When meeting new clients I would try to put them at ease and make them feel welcome at the clinic. I did this by explaining how the clinic operated. I also wanted to know how they had heard about Agape and what they expected from it. I experienced this introductory phase positively.

I then proceeded to ask clients about their reason for coming and allowed them to talk until they had finished. The rest of the conversation followed a predictable pattern. I would allow the client to take and maintain the initiative whilst I would resort to the more passive role of listening sympathetically. My first session with Jonathan (17-07-1998) is a case in point. I wrote in my process notes:

I let Jonathan talk; as long as he was making sense, I let him talk. For two and a half hours I let the man talk! The question I am asking myself is whether this was the most helpful thing I could have done for him.

Nevertheless, from all the information which Jonathan volunteered, I managed to identify the presenting problem, the desired outcome and the
attempted solutions (Watzlawick et al., 1974). Admittedly, the clarity which I gained in doing so was lacking while I was conducting the interview.

**Presenting problem**   Jonathan found himself in an unhappy marriage. He felt that he had been coerced into this marriage by his mother, who had warned him that if he did not marry his cousin, she would not permit him to ever visit her grave. Jonathan then married his cousin and felt that from then on, all his problems started. He cited many reasons why his marriage was unhappy and why he wanted to divorce his wife. He wanted to know if I thought he was making the right decision, and whether he was being unreasonable in wanting a divorce.

**Desired outcome**   Jonathan wanted to divorce his wife, go to the woman he had loved since before his marriage and ask her to marry him. Although she was married (to a man who had two other wives), Jonathan had met her husband and was sure he would let her go. Furthermore, Jonathan wanted his mother's blessing on this course of action.

**Attempted solutions**   (a) Jonathan engaged in behaviour that frustrated his wife, in order to prove to her that he was not the right man for her; (b) Jonathan went to various authorities (social workers, psychologists, marriage counsellors) whom he hoped would support his case.
I was pleased that I could organise this information according to the MRI model. Yet I was dissatisfied with my accommodating approach. I wrote:

*To interrupt and get [him] back to the main point (who decides what that is?) might be more perturbing... yet I shall run the risk of being insincere...*

**The Inner Compass**

In terms of the hypotheses offered above, it was becoming increasingly clear that there was more to my difficulty that met the eye. My lack of knowledge and skill undoubtedly played a role but could not fully account for the recurrent pattern of relinquishing the initiative during therapy. Accordingly, my next task was to determine whether and to what extent I tended to relinquish the initiative in other contexts.

I noticed that in everyday conversations I seldom interrupted people when they spoke and would usually wait for a gap in the conversation before I responded. I often allowed other people to define the rules of the relationship and then played along. In conversations that did not really interest me, I felt that my input would not make a difference anyway, and so opted for silence.

My explanation for this was that I did not like it when people
interrupted me and I assumed that most people felt the same way. Another assumption I held was that others would give me all the information I needed without me having to ask. I only needed to give them enough time. I suspect that this had something to do with my father's and my typical pattern of relating. Throughout my childhood, whenever we worked together on some project I had to listen very carefully to what he said. Not following his instructions to the letter often led to a serious confrontation and extreme unpleasantness. In addition, my father seldom responded when I asked him for clarity on some instruction that he had already given. He considered the matter closed, believing that I should have listened right the first time. I learned to become extremely diligent about listening and understanding as much as I could from what people said so that having to ask for clarity would not be necessary.

My basic interactional style could thus be summed up as follows: I tended to take the 'one-down' position and allowed others a great deal of space. I was also careful not to enter that space for fear of eliciting a negative response.

The realisation that my personal style limited my options in dealing with clients marked the beginning of change. I knew that in order to create movement in therapy, I would need to take ownership of and responsibility for the therapeutic conversation. I needed to define myself as the one who took the initiative and who was responsible for creating a space in which
healing could occur. In practice, therefore, I needed to define what was permissible in the therapeutic context and what was not.

But how was this to be achieved? Sticking to the MRI approach was perhaps the easiest way, yet it contradicted my personal style. Moreover, I also felt rather uneasy about applying the MRI model at Agape. To do so may be seen as a veiled criticism of my clinical supervisor's way of working. I could "hear" Stan's counterarguments to applying such an approach. Although this was uncomfortable, I did not reject Stan's ideas out of hand, but rather regarded them as a gift which complemented my therapeutic style and helped shape my identity as a healer.

Nevertheless, I regarded myself as fighting for survival, and it was for this reason that I felt justified in helping myself in order to help my clients. I also firmly believed that a therapist incapacitated by feelings of helplessness was not acting ethically.
CHAPTER 6

CONSULTING A MAP

By now I had completed the reconnaissance phase of my research. Realising that I was my own best enemy when it came to taking charge of the therapeutic situation, I decided to review the basic text on the MRI approach (Watzlawick et al., 1974). Without a clear grasp of its essential features, my chances of making progress were doubtful.

Careful reading of their section on the practice of change revealed that the MRI team followed a simple four step procedure, namely,

1. obtaining a clear description of the presenting problem
2. investigating the attempted solutions
3. defining the desired change in concrete terms
4. formulating and implementing a plan of action in order to achieve the said objective

According to Watzlawick and his colleagues (1974), translating the presenting problem as well the desired change into clear and concrete terms serves to separate problems from pseudo-problems and aids in avoiding unrealistic goals. In doing this the therapist is safeguarded from compounding rather than resolving the problem. Paradoxical interventions are considered to be particularly effective in resolving problems. The authors
use the predicament of the insomniac as an example. Trying to fall asleep is seldom successful – but being forced to stay awake is bound to break the deadlock.

**The Map is not the Territory**

Initially I made fairly good progress in the sense that I was able to take and keep the initiative when talking to clients. This is illustrated by an excerpt from a conversation with Kate and her son Thabo (12-8-1998).

(T=therapist, M=mother, S=son)

**T20** You say that sometimes you get a bit impatient with Thabo, because it looks as if he takes a long time to understand.

**M20** Ja, I sometimes think that he is just, let's say, stubborn. That is why most of the time I become so harsh.

**T21** Do you experience this as well, Thabo? That sometimes your mother gets impatient with you?

**S21** Yes.

**T22** Why do you think she gets impatient?

**S22** I don't know.
T23 [to mother] Why do you think you get impatient? What is it that he does that frustrates you?
M23 For example, I can tell him to do something, he won't do it.

T24 Why is that?
M24 [after long silence] He forgets.
S24 When she tell me, that thing come into my mind then I forget the thing she told me.

T25 So something comes into your mind and then you forget.
S25 Yes.

The presenting problem was that Thabo experienced upsetting hallucinations. His mother wanted to know whether the hallucinations were related to a medical condition. By the looks of it, this case simply required a referral to a doctor or psychiatrist. However, if this was so, applying the MRI model would be needless. This raised all kinds of doubts as to how to proceed. In terms of the Agape philosophy, presenting problems were regarded as “entrance tickets” and therefore not be taken at face value. I just had to keep going. Yet I desperately wanted to move beyond the typical Agape approach. The sudden onset of Thabo's problem in the absence of any head injury or serious illness made me think that exploring family dynamics could be worthwhile. I therefore proceeded according to plan and inquired about the mother’s typical reaction to her son’s hallucinations. In the course of doing so it became clear that she had a longstanding
dissatisfaction with his "laziness". In fact she broke down and cried while revealing this information.

Shifting the focus from hallucinations to laziness was a relief because it allowed me more scope in applying the MRI model. I believed that laziness represented the typical kind of behaviour which could become a genuine problem because significant others either took it too seriously or not seriously enough (Weakland, Fisch, Watzlawick & Bodin, 1974). Nevertheless, conducting a proper "MRI" session remained a challenge. Once I had obtained the necessary information, I felt pressed to do something with it. But I did not exactly know what or how. What I did know was that my clients were expecting some kind of feedback regarding their problem and that I needed to provide it before the conclusion of the session. I therefore decided to consult John, one of the Agape supervisors.

John regarded Thabo's symptoms as a metaphor for a problem in his family. Despite the fact that he was growing up, his mother's domineering attitude prevented him from having a voice of his own. The hallucinations could be an indirect way of revealing his feelings. Hence his suggestion that I prescribe a ritual which would simultaneously allow him to act according to his age and prevent the mother from taking too powerful a role vis-a-vis her son. I conveyed this message to my clients as best as I could.

Afterwards I documented the experience with a view to organising the information obtained in terms of the MRI model. I tried to get a clear
picture of the presenting problem, the attempted solutions and the desired outcomes.

**Presenting problem**  According to his mother, Thabo is being haunted by images. When he looks at others he sometimes becomes frightened because their faces change horribly. For instance, when he visited his uncle the latter's face changed into a skull with blood dripping from the eye sockets. At other times he is followed or chased by snakes.

His mother wants to know whether there is anything organically wrong with him. She wants to rule out any medical problem before she takes him to a prophet or sangoma [traditional healer]. She also mentions that this condition started suddenly 3 months ago. Since then his schoolwork has deteriorated. She also reports that he is very “forgetful” – he seldom performs the tasks she asks of him and then says that he forgot.

There seem to be two concerns for the mother. Firstly she is concerned about the hallucinations, which she is at a loss to explain. Secondly she is concerned about his deteriorating schoolwork and slackness in obeying her. She attributes his inadequate performance to laziness.

**Attempted solutions**  Concerning the hallucinations, Kate took Thabo to her father who is a bishop at a local church. He was able to
calm Thabo down and "speak nicely to him". Kate also comforts Thabo every time he has an hallucinatory experience.

Thabo is not allowed to do any sport until his schoolwork improves. His mother warns that if he fails he will be in the same standard as his younger sister. She thinks that he is using his "forgetfulness" as an excuse.

Observations   Thabo speaks very softly to his mother and shows a great deal of respect. However, he takes his time in answering her questions. His mother shows frustration at this. She needs to repeat questions more than once before he responds.

Intervention   I prescribed a ritual which required the mother to treat Thabo as a person with unique feelings and thoughts. He needed to express these since he was growing up so fast.

Unfortunately I was not able to evaluate the effectiveness of this interview since my clients did not return. However, the mere fact that things turned out this way was rather disconcerting. Perhaps I should have complied with the mother's initial request by referring Thabo to a medical practitioner? Did I really know what I was doing in applying the MRI model?

Another opportunity to try my hand at the MRI model presented itself in the form of Sarah and Tsepo (23-09-1998). For the sake of brevity, my notes on the case are presented first.
Presenting problem  Sarah's daughter Rowena died of illness in November 1997. Rowena had one son, Tsepo. Tsepo's father left his mother when he was born. After Rowena's death, Sarah took the responsibility of caring for Tsepo. Sarah came to Agape seeking counselling for herself and her grandson to help them cope with Rowena's death.

Upon asking Sarah why she sought counselling only now (almost a year later), she said that she was not satisfied with the amount of effort Tsepo was putting into his schoolwork and thought it might be because he was still upset about his mother's death. The school had reported that Tsepo did not pay enough attention in class and seemed distracted. His marks had also deteriorated over the last year.

Attempted solutions  Tsepo loved soccer and cricket, but Sarah wanted him to stop all sport activities until his marks improved. He came home at 5 o'clock after cricket practise and then watched TV. She became angry with him and scolded him for not studying. They would quarrel about it with Sarah shouting Tsepo down in the end. He would give in and promise to improve, but never did.

Observations  Tsepo did not speak much. He was quiet and seemed distracted. He responded with short, "emotionless" sentences. Sarah was close to tears during almost the entire first session.
Interventions I reframed Tsepo's poor school performance as a way of honouring the memory of his mother. Sarah could identify with this explanation. By exploring other ways of remembering her, there was a chance that his schoolwork would improve.

Sarah and Tsepo attended three sessions only. In the third session, Tsepo told me that it was much more pleasant at home – he was able to do his homework and only asked his grandmother for help when he got stuck. She seemed to have taken a more relaxed attitude toward his schoolwork. They had made a special place in Tsepo's room for remembering his mother. Previously, Tsepo had only been able to visit his mother's grave when his grandparents did so. Now he was able to ask them whenever he wanted to visit the graveyard and they would oblige by taking him.

During our sessions, Sarah often entreated me to "fix" Tsepo. I was proud of the fact that I could resist her demands by redefining Tsepo's behaviour as a natural response to loss. I suggested that she reduce her check-ups on Tsepo's homework and allow him to take more responsibility for his schoolwork. We talked about ways of remembering Rowena. For example, Tsepo could visit the grave and make gifts for his mother which were to be placed in a special place of remembrance.

At this point I was thrilled with my growing ability to take the initiative during therapeutic conversations. With Sarah and Tsepo I felt that I could sufficiently identify areas that I wanted to focus on. Even my attempts at
producing movement in therapy proved successful to an extent. However, this happened despite the fact that I was not making 'proper' MRI interventions. Be that as it may, I felt that I was on my way.

**Losing Momentum**

As time went by, I noticed a worrying tendency. I was rapidly reverting to my old way of working, which was to conduct interviews in a *laissez faire* manner. Upon reflection I realised that I was finding it incredibly difficult to follow the MRI approach within the Agape context. The reason for this seemed to be that I was trying to marry two totally different therapeutic approaches. Moreover, experimenting with MRI type sessions amounted to going against the Agape grain and therefore had to be done 'secretly'.

In discussing my dilemma with Gert, it became evident that my situation was even more complex. The requirements of the Agape context apparently fitted my preferred style perfectly. I felt that I had a natural talent for doing what was expected of me at Agape. The ideology at Agape favoured respectful human contact and taking the stance of a non-expert. Consequently, when I reverted to simply being myself without planning or trying anything, my clinical supervisors were satisfied. I could get by without too much trouble. However, the end of my UNISA training was rapidly drawing near. I could only hope that my internship would afford me new opportunities for capitalising on the gains I had already made.
CHAPTER 7

A CHANGE OF SCENERY

The bulk of my work up until the end of 1998 was to record my attempted solutions and to evaluate them in terms of their effectiveness in producing change. I wanted to experience movement in my therapy cases as well as in my development as a psychotherapist. My attempted solutions had consisted of implementing the MRI model to the best of my ability and evaluating the results. However, I experienced some difficulties in applying the model for reasons which I have explained.

At the beginning of 1999, I started my internship at 1 Military Hospital in Pretoria. I expected the new context to be totally different from the one to which I had grown accustomed over the previous two years. Needless to say, I was not disappointed.

One of the first and most noticeable differences was that with almost all of my clients I could converse freely in Afrikaans (my home language). This made communication less stressful. I found it easier to jump levels of understanding and to play with words, meanings and assumptions. Furthermore, clients generally treated me as if I were an important person and made me feel as if I could do something for them.

Listening to the concerns of my fellow interns made me realise that I
had been in stormy waters slightly longer than them. I felt much less intimidated by the difficulties of the therapeutic environment. Furthermore, my training in systemic therapy led me to believe that I was better equipped for the task at hand. I soon realised that my status had also changed. I was seen by the staff as a colleague who had a job to do, like anybody else, rather than as a struggling, inexperienced student. Our discussions focussed on how we could best do the job, rather than how I could improve. When I discussed cases with my supervisor, we would try to make sense of what was happening in the sessions, after which he would give practical suggestions as to what I could do during subsequent sessions.

**Difficult Terrain**

My first patients at the hospital were a couple, Derek and Nadine. Nadine had been receiving psychotherapy for depression and the psychologist had who treated her referred her for marital counselling.

When I spoke to her over the phone she requested "marital counselling in order to resolve personal conflicts". According to her, she and her husband had gone through a bad patch. Derek had been retrenched and had spent a long time doing nothing and not really making an effort to find other employment. During this time Nadine had had to carry the financial burden. Now that Derek had found employment again, she was reluctant to relax and to trust him to do his share. She has been in control of everything in their marriage since his retrenchment and even though she hated it, she was afraid to return some of the responsibility to him. She wanted Derek to give her
some guarantee that he would never "drop" her again. Derek resented the idea of having to prove himself to her, and felt that Nadine would in any case not accept any "proof" since she had convinced herself that it would not last. Unable to resolve this conflict, Nadine decided to seek marital counselling.

Over the course of the first two interviews we managed to define their problem as follows:

Derek and Nadine want to find a way of resolving their conflicts. Whenever they argue, Derek persists until he wins the argument. Nadine then reacts by hating herself for being such a pushover and becomes depressed. When Nadine refuses to budge, which is usually when the argument is about money, Derek ignores her for days. In the end they disagree about almost everything, and neither is prepared to give an inch.

At the end of the second session, Nadine asked me what I thought they should do, given the information they had presented. I answered that I needed more information before I could make any suggestions. After seeing them together for two sessions, I suspected that if I did not do something special during the next session, they would not return. Since I was eager to prove myself in the difficult arena of marital therapy I decided to review the Brief Therapy literature (Watzlawick et al., 1974; Weakland et al., 1974) with a view to selecting an appropriate paradoxical intervention. In doing
so, I realised that I did not nearly have enough information for designing a useful intervention. I knew that the couple wanted to find a way to resolve their conflicts. But this was a very vague goal, and one that was not stated in clear operational terms. In addition I realised that I did not know what their attempted solutions had been in the past. Neither did I know what the effects of those had been. Once more I had failed to follow the MRI map.

I resolved to go strictly by the book in the third session. I was not going to let them talk or argue about anything before we had defined the problematic behaviour as well as the attempted solutions in clear and concrete terms. In addition they would need to specify (in practical behavioural terms) when they would be satisfied that a change had taken place.

Unfortunately, I never had an opportunity to implement my plan. The couple never returned for the third interview. I was, however, forcibly reminded of the necessity of working thoroughly when using the MRI model. I needed to give a lot more attention to defining the problem, the attempted solutions and the desired outcome in concrete terms. What concerned me though was why I had not been able to follow this line of approach right from the start. Upon entering my internship I had been committed to practising the MRI model at every available opportunity! The most feasible explanation was that I felt intimidated by the situation. The daunting task of managing intense marital discord was rather unsettling to say the least. Nevertheless, I was grateful for the experience: it made me realise that there was much more to the MRI approach than met the eye!
My first rotation at 1 Military Hospital was in Psychiatry, where I was required to attend to both in- and outpatients. Most of these patients were diagnosed with depression. One such a patient was Valerie. Her eldest child, a daughter, had died in a motor vehicle accident on the way home from her parents' divorce court hearing. Valerie had been very close to her daughter and after two months still could not believe that she was really gone. She still hoped to wake up from a very bad dream. She lost her appetite, retreated into herself and could not face living without her daughter. When she talked, her voice was soft and flat. She said that she had always been a sparkling person, but now her son (then in Grade 8) and her colleagues at work told her that they did not recognise her as the same person. They had all prayed for her and offered their sympathy and help. After two months however, she got the impression that everyone was tired of her mourning and that they wanted her to get on with her life. Her boss eventually insisted that she be seen by a doctor and it was in this way that she found herself in the psychiatric ward.

Valerie did not seem to mind being in the psychiatric ward. It offered her time to think and be with herself without the daily responsibilities of household and work. She was, however, worried that she was losing her mind and would never recover. Everybody else in her life seemed to think that two months was time enough to work through her terrible loss. Valerie was not so sure.

I found it difficult to define Valerie's problem clearly. She was sad and
I found it difficult to define Valerie's problem clearly. She was sad and she looked like she wanted to be sad. I decided that her depression was more a problem to the people around her than it was for her. She was in mourning and I decided to respect her timing. I did not feel it necessary to speed up the process. I resolved, therefore, to legitimise any feeling she might express, whether this was anger, sadness or hopelessness. I wanted her to feel that no matter what she wanted to express, it would be fine with me. My gut feeling was that her psyche would heal in time and that my job was merely to confirm her worth as person while she endured this incredible pain. Valerie was in crisis. I wanted to provide a safe place for her to be in this crisis.

Was this MRI therapy? I took note of how the people in her life tried to help her. I also took heed of the effect this had on her. But I refrained from getting her to formulate concrete goals which we could pursue during therapy. My only concern was that she be afforded as much time as she needed to heal.

After three weeks she was discharged and came to see me on an outpatient basis with her son. At this point the presenting problem was that she tended to be overprotective of her son and was worried about the effect this had on him. At this stage I could revert back more formally to MRI therapy, since here was a problem that we could agree on in behavioural terms. Valerie, her son and I spent the next two sessions trying to define their individual and mutual goals for therapy. The son wanted his mother
to allow him to use his skateboard and to visit friends. She wanted him to be home by a certain time and to contact her when he would be late. They stated clearly what they expected from each other and negotiated which of these expectations were realistic and which were not.

Once these goals had been established, they seemed to be satisfied and did not return. I did not even have a chance to plan an intervention. My reaction to their not returning was that the process of negotiating reasonable expectations had been sufficient.

Making Headway

Around March of that year I realised that in most cases I seldom reached the phase of planning an intervention. I noticed that I spent a fair amount of time ironing out the definition of the problem and the desired outcome. I made quite sure that the patients decided exactly what they wanted to achieve. It seemed that once the client took responsibility for what he or she wanted (provided that it was realistic) then he or she would find their own way of getting there. There never was a single instance in which I was required to give a paradoxical instruction.

A case in point was Andrea. This, I believe, was probably the most important case in terms of my development as a therapist. Andrea represented a watershed for me in many ways.

Andrea requested help in divorcing her husband, Robert. She stated this
as a very clear goal of therapy. However, I regarded the request as unrealistic at the time. In the end we decided on taking smaller steps – the first step being to initiate a conversation between her and her husband in which they discussed their relationship. I organised a joint meeting which went relatively well. During that session I facilitated a conversation about how their relationship had initially been defined and how the definition had changed over time. My main aim was to foster a conversation between the two of them. This would allow me to take the role of impartial observer and thus prevent the husband from blaming me for siding with his wife. After the session Robert clearly indicated that he was not interested in any further discussions. Andrea was subsequently discharged and started seeing me on a regular outpatient basis.

In the weeks that followed we spent most of our sessions defining what Andrea really wanted and why she thought that this would improve her situation. Week after week she complained about not being able to take the final step of divorcing her husband and wanted to know from me why that was. I usually counteracted with a question: even if I would provide her with an answer, would she find it easier to take the step?

Andrea expressed continual doubts about the legitimacy of how she saw the world and did not know how she was supposed to feel and act. In the light of this, I made a point of assuring her that whatever was happening to her at the moment had its own wisdom and that she should trust the process (this was an interesting counterpoint to the attending psychiatrist's view
which was that she could easily develop a full-blown and undesirable psychosis. I stayed with whatever she presented during the sessions and expressed my respect for her ability to survive. I did not push her to divorce her husband, but assured her that when the time was ready it would happen. At least half of each session was spent in defining exactly what it was about her situation that presented a problem, how she would like it to be different and what would be necessary to change it. The following excerpt of our conversation on 01-03-1999, serves as an illustration.

T5: What exactly is the problem that you would like to solve? Is the problem that you cannot be who you want to be when you are with Robert or is the problem that you cannot tell Robert about how you have changed?

A5: The two are related...

T6: Yes they are, but what is the problem you want to solve and how will you know when it is solved?

A6: I want to....I don't think....how I have changed influences my life in total, I cannot go back to how I have been. I don't think Robert can be where I am now or that he will ever be there. It is not a road which he would ever take. He is not open to the road that I am on: when I want to discuss a certain book with him, he would immediately say that that book is crap and not worth discussing. So, if I stay with him, I won't be able to be the person that I want to be and therefore, yes, I want to go away.
T7: If you could have one wish, what would it be?
A7: Just one wish?

T8: Yes.
A8: I would wish that all my wishes come true!

T9: Cop-out! (Laughs) One wish.
A9: I would like somebody like the fairy godmother to swing a magic wand so I would suddenly find myself in my own place with a telephone that is connected.

T10: What does this place look like?
A10: What does this place look like? All my things are there.

T11: Ok, all your things are there, is this a place like a home where you stay or is it a workplace like an office?
A11: No, it doesn't matter, any one of the two.

T12: Choose.
A12: Work, workplace.

T13: So it is a place where you work, not a home?
A13: Yes it is a workplace, but there is place to stay overnight, but you don't have to stay there forever.
T14: Okay.

A14: A place of my own. I see my computer and books there.

T15: And how would your relationship be with Robert?

A15: I would not want to see him ever, ever again in my whole life.

T16: So, your ideal situation is that you are sitting in your workplace, and if you think about Robert your feeling is that you would never have to speak to him again?

A16: Yes, that would be a great relief.

T17: You would never speak to him, never phone him on his birthday, basically avoid all contact with him?

A17: That's right. Any relationship I have ever had with people, once it is over, it's over.

T18: So you don't want to remain friends with him after the break-up? You want to make the cut clean and final.

A18: I don't think it would be possible from my side to remain friends.

T19: We are not talking about thinking, but about wishing.

A19: Oh, we are still with the wish. No, I would never want to see him again. If he could live in another country from me it would be great.
The learning and teaching of systemic therapy - An action research approach

T20: So you don't care if he makes it or not, whether he commits suicide or not...

A20: It's not that I don't care, I just don't want to know about it.

T21: So when you envision your ideal life, it is completely void of Robert.

A21: Yes.

In May 1999 Andrea separated from Robert and moved into her own place. The divorce was finalised two months later. Her definition of the problem then changed to the difficulty of adjusting to her new life. I continued seeing her till the end of that year.

At this stage I had realised that I no longer felt inadequate in my therapy sessions. I became very excited about this, although I was not exactly sure how this had happened. The purpose of my whole research project was to put a stop to the feelings of inadequacy that paralysed me. It seemed that although I was not following the MRI model to the letter, my situation had changed for the better. I discussed this with Gert and he suggested that I write up my own theory of psychotherapy. It was important for me to identify exactly what I was doing in therapy and to articulate the underlying principles. After some serious thinking I was able to produce the following document, dated 30-05-1999.

1. I find it easier to work with clients when I feel a connection with
them. The strength of the connection is influenced by my own values and emotional reactions towards the client's problem. Feeling connected can best be described by the term “empathy”. When I become fascinated with the client's unique situation, I know that a connection has been formed.

2. I believe that the crisis which the client is experiencing is a sacred event. This means that the intensity, painfulness and complexity of the client's problem needs to be respected at all cost. Not only can I never fully understand what s/he is going through, but by trying to understand I am intruding on 'holy ground'. If the client is somehow able to live through the crisis, it will lead him or her to a gift - a different existence with different possibilities. Fear is experienced because of imagined sacrifices required to live through the crisis or the imagined lack of circumstances worth living for after the crisis.

3. The client often has a specific request, for example “I want you to motivate my son to perform better at school - he is not achieving his potential”. It is important for me to achieve clarity on the definition of the problem in behavioural terms. This needs to be done before solutions or interventions are attempted. Let me use an analogy to explain further. When I (a non-expert) notice a noise in my car's engine, I am tempted to make a layman's diagnosis - the tappets need replacing. I then request a qualified mechanic to replace the tappets. If he agrees to my request without ascertaining that it is indeed the
tappets that are causing the problem, chances are that the noise will remain. Alternatively he could ask me why I want the tappets replaced and I could tell him about the noise. In this way the mechanic could investigate the cause of the noise and the original problem would be taken care of more effectively.

4. I trust the client's pace. The client is exactly where he or she should be at any particular moment in time. For example, one my clients felt frustrated that she was unable to request her husband for a divorce. Yet she could not deny that the prospect of doing so filled her with tremendous apprehension. Assuring the client that both her frustration and perceived inability to act were legitimate removed much of the pressure to act immediately. No matter what the client feels - hate, anger, frustration or self-loathing - all of these are to me real and therefore worthwhile.

5. Sometimes the client is not asking for solutions, but wants assurance that somebody understands what he or she is going through. This was brought home to me by one client who disqualified anything I tried to do in order to help. She was not ready to work on solutions before she was sure I had understood the full impact of her suffering.

To summarise:

1. I am interested in what the client brings.
2. I see the client as perfect. No disorders, no built-in insufficiencies, but whole and perfect.

3. I respect the systemic wisdom of the situation the client is in.

4. I do not assume that I will ever understand the experience of the client, but if I am really interested I might get enough of an indication of what she or he is experiencing.

5. I test my own understanding of the situation with the client as regularly as possible.

6. I refuse to consider solutions before I have a sufficient understanding of the ecology of the client’s crisis. What exactly is unbearable in the present context, how does this discomfort manifest and who else is influenced by it? For how long has it been unbearable or uncomfortable and who helped to make it uncomfortable? What has been attempted to relieve/solve this discomfort and by whom?

7. No solution can be discussed before there is clarity on what the preferred outcome looks like.

I was surprised that I could say this much about my approach to psychotherapy. After all, I had spent nearly two years proclamation my ignorance about the matter. But there it was in black and white. Somehow the tide had turned. Compared to my situation a year earlier, I was feeling a lot more comfortable. I experienced sessions as having a lot more movement. I was working according to specific guidelines. I had a fair idea
of what to focus on and what to avoid. Most importantly, I was becoming more skilful by the day.

A Growing Sense of Direction

The beginning of the next rotation heralded a change in my working environment and also a possible adjustment in my way of working. After six months on the psychiatry unit, I was assigned to the child psychology section where I would work with children under the age of sixteen and their parents. I was excited about this since my Unisa training had familiarised me with the theory of family therapy and I felt a natural affinity to children.

I soon found that my growing proficiency in applying the MRI model was quite adequate for the task at hand. When I asked for concrete examples, I often found that the parents played a major role in the formation and maintenance of the problem. A case in point was six year-old Alicia.

Alicia’s regular anger outbursts were her mother’s main concern. She would slam doors and shout at the other family members when she was upset about something. This was in contrast to her sister, eleven year-old Michelle, who never showed any sign of being upset. According to the mother, this behaviour started when Alicia’s grandfather, to whom she was very attached, died about two years previously. Alicia’s behaviour upset the mother and was ignored by the father.
I asked for an example of the last time this behaviour had happened. The mother recalled that her husband had teased Alicia until she lost her temper and stormed out of the room, slamming the door. Additional examples revealed that the father would tease or humiliate Alicia as a form of punishment.

In a follow-up interview with both parents, it came to light that the father had been subject to the same treatment when he was a child. He had also been prone to temper tantrums and emotional outbursts. The parents furthermore confessed to arguing loudly about most things, including matters of discipline. This typically happened in front of the children. The father shouted loudly and often slammed the door when angry.

Over the course of three interviews, the parents' concern over Alicia's behaviour changed to a concern about their own relationship and the effect this had on both their children. They no longer saw Alicia's behaviour as a problem, but as behaviour which reflected their family's way of dealing with frustration. In fact, the parents ended up being more concerned about Michelle's lack of emotionality than Alicia's unequivocal expressions of feeling. Therapeutic encounters of the "Alicia" kind happened quite frequently at the child psychology unit and I began to realise that I was in fact consolidating my therapeutic approach.
In reflecting on my research experience I was able to identify those factors which allowed me to move from a position of helplessness and confusion to one of confidence and hope.

(1) At the start of my training I expected to feel insecure. However, I was unprepared for the quiet feeling of desperation which gradually took hold of me. The one thing that kept me going though was my implicit trust in my clinical supervisor. His competence and wisdom inspired me. He was always there for me and managed to dispel my worst fear, namely that I was unfit to be a therapist. However, I was largely unable to translate his valuable ideas into practice.

(2) The feelings of desperation were somewhat allayed when my thesis supervisor introduced me to action research. The mere thought that it could be instrumental in resolving my training impasse brought a measure of relief. Following this approach required me to execute specific procedures. The first was the verbatim reports of my conversation with clients. This allowed me to analyse my interaction with clients in detail. Needless to say, this was a daunting prospect, but it satisfied my need for structure and direction.
(3) The value of this activity lay in its diagnostic potential. It revealed a rather haphazard type of communication. The diagnostic process was continued by probing (Minuchin, 1974) my contact with clients through trial and error. Lewin (1946) maintains that trying to change a situation is the royal road to understanding it. Experimenting with the technique of tracking (Minuchin, 1974) not only improved my communication with clients, but also highlighted the fact that I was lacking a clear frame of reference in terms of which to conduct therapy.

(4) In consultation with my thesis supervisor, I subsequently decided to try the Brief Therapy model (Watzlawick et al., 1974). The latter was not only easy to understand but provided a structured approach to therapy. The result was instructive: I realised that I was given to taking a "one-down" position vis-a-vis my clients. In fact, this tendency reflected a personal style that characterised most of my relations with others. It was this style more than anything else which confounded my attempts at being useful to others.

(5) Becoming aware of the way my personal style impacted on the process of therapy motivated me to take action. I had to take charge of the therapeutic situation. Given my need for structure, I therefore decided to intensify my attempts at applying the MRI model. Eventually my persistence paid off – I was at least able to take and maintain the initiative in talking to clients. However, I remained unsure as to how and when to intervene for purposes of change. In some instances the
MRI model did not even seem applicable. This left me confused and compelled me to consult my Agape supervisors. The result was even more confusion since I ended up trying to marry two different approaches to therapy!

(6) Entering my internship fortunately afforded me an opportunity to capitalise on the gains that I had made until then. The new context was no less demanding, but it exposed me to a different client population as well as a different organisational setup. The more structured environment and the task-orientated approach of my new supervisors contributed significantly to my continued development. Yet it was perhaps the client population who taught me the most. Those who had either suffered grave losses or were about to experience such a loss compelled me to slow down and to relinquish my need for effecting drastic change. Somehow I started feeling less inadequate as a therapist. Paradoxically speaking, I was making a real difference to the lives of others by not resorting to drastic interventions!

Discussion

In identifying the factors which enabled my professional development, the following important themes became apparent:

My Need for Structure

During my first year at Agape I desperately wanted to learn how to do therapy. Instead I was told how to be with clients. As a result my frustration
mounted. This happened despite my loyalty to my supervisor. Engaging in action research brought relief right from the start. Doing specific tasks provided structure and a sense of direction. This sense remained throughout the duration of my research project. Granted, implementing the suggested action plans was not always easy, but I invariably learnt something valuable as a result. Furthermore, those tasks removed much of the ambiguity that usually accompanies the learning of psychotherapy.

The Determining Influence of Personal Style

The dramatic impact which my 'one-down' style of relating had on the learning process became evident during the reconnaissance phase of my project. Since it is inconceivable that any therapist can ever refrain from taking a leadership position vis-a-vis clients, my 'one-down' tendency was a definite drawback. Arguably, taking initiative in rendering a professional service depends on having a clear idea of what to do and some skill in knowing how to go about it. It is therefore to be expected that taking a 'one-down' position in relation to clients is unavoidable at the beginning of training. Yet in my particular case, this tendency was compounded as a result of my natural inclination to assume the 'novice' role. The intractability of this role was further illustrated by my protracted struggle with the MRI model. Whenever the going got tough, I reverted to being my usual self ('winging it' in sessions; being the non-expert).

An even more significant observation can be made regarding the persistence of my personal style. In the end it fundamentally determined the
way in which I used the MRI model. The MRI model required that I be
directive in prescribing interventions. This contradicted my natural ‘one-
down’ tendency. Thus it happened that I not only failed to move beyond
implementing its diagnostic phase, but never even needed to make calculated
or paradoxical interventions.

The Influence of the Training Context

The situation at 1 Military Hospital contrasted with that of Agape in
several major respects. It was structured and organised such as would be
expected from any military setup. The clientele mostly came from a lower
middle class background. I could converse with them in the vernacular. The
opposite was true of Agape. Here the emphasis was on "creating community"
and the clinic resembled a "walk-in" facility in many ways. Clients were
mostly black, poor and had little education. I joined this establishment as a
young white Afrikaans speaking male with no experience of life in a
township. These clients expected me to do something for them – to make
things happen. This amounted to an impossible task. I was cast in a 'one-up'
role, whereas my natural tendency dictated just the opposite.

Discerning these themes made me wonder whether I would have become
the therapist I am if my training had been different from the start. What
would have happened if I had started my training in a context like 1 Military
Hospital? Most likely my need for structure and direction would have been
met and my excessive performance anxiety might possibly have been
prevented. However, I did not naturally fit with very structured models of
The learning and teaching of systemic therapy - An action research approach

of ethical relationships. Journal of Marital and Family Therapy, 18(3), 283-296.


