

**BEYOND CYBERNETICS:  
CONNECTING THE PROFESSIONAL AND PERSONAL SELVES OF THE  
THERAPIST**

by

**SNEZANA MAROVIC**

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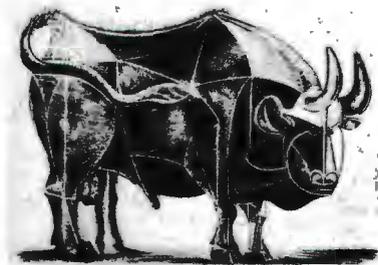
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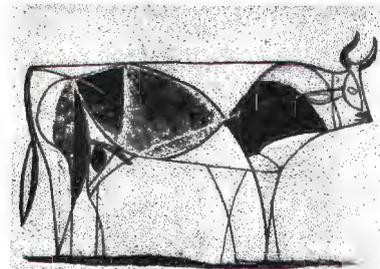
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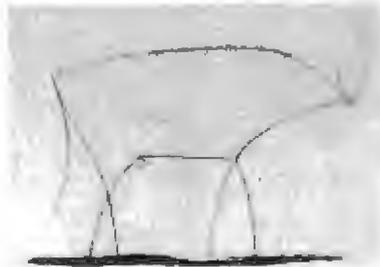
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## SUMMARY

This research explores the meaning of the first and second-order therapeutic stances with reference to the therapist's professional and personal development. The dominant positivist paradigm was reflected in the therapist's initial position of expert observer, outside of the observed. The observed phenomena were a group of children suffering from thalassemia major, a terminal genetic disease, and their mothers. The initial idea of short-term intervention and focus on the observed evolved into six-year journey where the observer and the observed became an interconnected unit of observation, understanding and change.

A first-order stance led to therapeutic stuckness, where the therapist's confrontation with her therapeutic failure and the limitations of the dominant paradigm provoked a deconstruction of the expert position and promoted a self-reflexive therapeutic stance. The author's self-searching process took her back to her personal self, her family of origin and the "wounded healer". The researcher moved from an initial disconnection between her professional and personal selves to an awareness of the interface between the two and, ultimately, to a unification of her professional and personal selves. Such development involved an individuation process moving from a narcissistic belief in her objective stance towards a therapeutic stance where she sees herself less as a powerful agent of change and moves to an increasingly higher order of integration of the professional and personal selves (Skovholt & Ronnestad, 1992).

The process with the children and mothers shifted from a focus on compliance and medical issues to more personal and emotional stories. The therapist's participation and collaborative stance created a context for change, where greatly improved medical compliance was just one of the many transformations experienced by all the participants.

The researcher speculates that development of a second-order stance requires second-order change, which comes "at the end of long, often frustrating mental and emotional labor" (Watzlawick et al., 1974, p. 23), promoting integration between the professional and personal selves of the therapist. The researcher therefore contends that

this process has important implications for psychotherapy training, supervision and continuing education.

### **KEY TERMS**

First-order stance; Second-order stance; Terminal childhood illness; Thalassemia major; Self-reflexive therapist; Therapeutic failure; Professional self; Personal self; Professional development; Work on family of origin; Interface between professional and personal selves of the therapist; Second-order change; Inter-connectedness; Training; Supervision; Continuing education.

## CHAPTER 1

### INTRODUCTION: ON BECOMING REAL

First-order cybernetics based on the cybernetic principle of feedback examines systems in relation to what goes into and what comes out of them (Becvar & Becvar, 1996). The implication of first-order cybernetics for the field of psychotherapy is that the therapist is an objective outsider who controls the observed system. In first-order cybernetics the therapist is the expert who sets the goals and intervenes to produce change (Hoffman, 1993).

While in first-order cybernetics the observer remains outside or apart from the system observed, second-order cybernetics introduces the idea of recursion, which implies a connection between the observer and the observed where the observer is part of the observed (Becvar & Becvar, 1996). But what does it really mean to be a participant, and how different is it for the therapist to participate? When we participate in the therapeutic process, how does this affect us, and how do our personal histories affect the therapeutic process?

Initially, the research for this doctorate focused on describing the therapeutic process in a medical context, with families and children suffering from a serious childhood illness called thalassemia major. Getting people to comply with the prescribed treatment is seen as one of the biggest challenges in combating the disease, with 20% to 50% of patients failing to do so (Rissman & Zimmer Rissman, 1987). My plan was, therefore, to explore the therapeutic work involved in improving group compliance with medical treatment.

I began with a first-order position: I was the expert and the objective observer who remained outside of the system I was observing. As the process unfolded, my delusion that I was in an expert and neutral observer position was replaced with a collaborative, participant mode. I discovered the meaning of second-order cybernetics. Taking a participant position created shifts in two directions. Group process moved to deeper and more significant themes, and to my surprise group members' medical compliance improved. On the other hand, this position created

some painful and challenging perspectives and dilemmas for me, which promoted my personal growth and enhanced the development of my professional self. Through this process I became free “to be oneself and acknowledge oneself as an individual with both positive and negative characteristics” (St. John, 1987, p. 96). As my awareness moved to the shifts in my personal and professional development, so the focus of my doctoral research also changed.

As the “expert”, I had started out with confidence, but within the first year I was confronted with many knotty issues and difficulties. As I worked alone with no possibility of bringing in a co-therapist or a team, reflecting on my own internal processes became a necessity (Hildebrand & Speed, 1995). I began to feel stuck, and I lost direction and confidence. The lack of progress activated feelings of helplessness, vulnerability, fear of failure and incompetence (Rolland, 1994). I also felt very lonely and unable to share my battle, as open acknowledgement of the possibility of failure is still unacceptable among peer professionals (Spellman & Harper, 1996).

Disclosing my struggle to the thalassemia group was difficult, as talking about failure requires courage and humility (Spellman & Harper, 1996). But it seemed that a parallel process occurred in the group, provoking a shift in our conversations to more honest and deeper levels (Counselman, 1997; Darwin, 1999).

In terms of the constructivist paradigm, and with the introduction of the notions of a participant mode and mutual influence, therapy is understood as a continuous interplay between the subjectivities of patient and therapist alike (Darwin, 1999). In such a context, therapist self-disclosure is seen as potentially enhancing intimacy and mutuality (Darwin, 1999). Self-disclosure on the part of the therapist has long been a controversial issue (Cornett, 1991), but disclosure of the therapist’s negative feelings seems to be the most difficult type of self-disclosure and may relate to therapists’ unwillingness to tolerate personal vulnerability (Maroda, 1999). Hoffman (1993) is one of the very few therapists who bravely admits that she sometimes experienced professional problems:

I will share my understanding of the constraints upon me; what the State or my own values or beliefs allow me to do or not to do. I will

share life stories of my own if they are relevant. ... If I feel troubled about process or “stuck”, I will share that too. (p.157)

When the process in the group shifted to a more personal level I felt more confident - but not for too long. V. H., 20 years old, was one of the oldest people in the thalassemia group, with a long history of very poor compliance. Because of his age he did not fit into the children’s group, where the oldest members were around 15 years. In addition, his health problems were very serious compared to those of everyone else in the children’s group. Accordingly, I saw him individually, and had been doing so for 3 years when in 1997 his medical condition deteriorated. His dying was slow and extremely painful, and perturbed me deeply. It also made me realise that I might have to act in a way that seemed alien or different from my usual therapeutic stance (Darwin, 1999).

Research suggests that the person of the therapist is a significant factor in his or her effectiveness with clients (McConaughy, 1987). I discovered that one of the issues making me ineffective was my inability to tolerate and facilitate my patient’s affect (McConaughy, 1987). The process with V.H. challenged me to use my self in a way that I had never attempted before. I had to learn how to share feelings with patients, not to be afraid of crying in front of a patient (Counselman, 1997), and to use touch as a therapeutic tool (Kertay & Reviere, 1993). In order to be effective, a therapist must be prepared to enter into a truly personal relationship with clients, and be able to handle intimacy (McConaughy, 1987). When the therapist takes the risk and acts in such a manner, she is faced with a lack of certainty as to the outcome, and she is also risking the disapproval of her peers (Darwin, 1999). On the other hand, she may achieve authenticity and the mutually beneficial resolution of therapeutic stuckness (Darwin, 1999). Authenticity requires facing up to vulnerability and fears of professional and personal inadequacy, some stemming from childhood and some from training and the expectations of the professional community.

V.H.’s painful dying and my struggle to accept it reinforced the understanding that the key lay in how I used my self. My subsequent facing of not just his pain and fears but of my own as well has once again proved beneficial to us both, patient and therapist (Counselman, 1997).

A therapist's degree of comfort in using the self is closely related to her level of personal and professional development. Therapeutic effectiveness can be enhanced when the therapist explores her limits and eliminates emotional and other blockages (Proskey, 1996). Becoming real in the sense of accepting personal and professional characteristics, both positive and negative, creates a space in which the therapist can risk being herself and can feel unthreatened by someone else's reality (St. John, 1987). The higher the degree of realness the less likely it is that the therapist will become defensive and will deny her own participation in the therapeutic process. Thus the personal therapy I started to undergo in 1995 expanded a space for self-reflections which sparked my awareness of personal issues that were interfering with my professional effectiveness. I was able to trace certain issues back to my family-of-origin and to significant events in my past. Exploration of the relationship between my past and present life and my clinical effectiveness provided a foundation for improving my clinical effectiveness (Winter & Aponte, 1987).

Continual development of the capacity to respond creatively in life situations as well as in therapy means being in touch with one's existential core in relation to one's life context at each period of time (Duhl, 1987). This capacity is enhanced through a self-reflective process which expands on narratives of the therapist's self and improves her personal and professional development. For me, this process was activated in a group for supervisors established in 1995 after I attended a workshop on "Approaches to Supervision" run by Pieter le Roux and Rob Shea of the Department of Psychiatry at the University of Rochester in New York (June/July 1995). The key concept in their approach to supervision was the self of the therapist and its impact on the supervisory process. The workshop inspired the creation of a support group focusing on self and family-of-origin experiences in relation to supervision and therapy.

On a personal level I discovered that a position of neutrality had protected me (and many other therapists) from participation in the process of therapy. The Milan group has established a principle of neutrality (Jones, 1988) whereby the therapist resists making any judgements. Neutrality is achieved by continuously shifting alliances from one member of the family to another, without excluding anyone (Selvini Palazzoli, Boscolo, Cecchin & Prata, 1980). The Milan team promoted the

idea that the therapist should suppress personal reactions and opinions. However, Golann (1988) has pointed out that family members draw inferences about therapists' emotions, thinking and values from how they behave. Hoffman (1993) says that her response to the question of neutrality was to "abandon not only neutrality but all aspirations to being 'meta' anything" and "frankly admitted subjectivity seemed to be a much more tenable position than holding on to supposedly objective values and norms" (p. 85).

A participant position for the therapist brings subjectivity into the frame, and this, for me, meant being touched by the pain and fear of working with terminal patients, which is inevitably a profound experience for the therapist (Counselman, 1997). Doing rather than feeling has been a traditional emphasis in therapy (Hildebrand & Speed, 1995) and I, too, began with the idea of doing and intervening. But the participation mode provoked a shift to a mode of "being" (Snyder, 1995). "Being" with a patient demands risk taking and abandoning the protective and powerful role of the expert, and this may result in a transformation process which has the potential to reach both client and therapist.

When the therapist positions herself as a participant in the therapeutic process, the use of self emerges as a significant factor in that process. The question of how to use self relates to how the therapist reads the flow of her own feelings in determining and understanding what kind of client or situation she is dealing with. Her self is also important in deciding in how she will respond to a client's or a family's dynamics or needs (Prosky, 1996). Issues related to the therapist's past or present family life may affect the therapeutic process, so that the therapist's understanding and mastery of these connections may be vital in achieving therapeutic competence and effectiveness (Winter & Aponte, 1987). The degree of resolution in her personal life will be reflected in knowing how to manage her reactions to unresolved issues in ways that will benefit her clients (Winter & Aponte, 1987).

The therapist's role as a participant in the therapeutic process, which derives from the theory of second-order cybernetics, has been acknowledged for several decades, yet one finds a minimal number of articles describing the personal meaning of this paradigm. I was stunned by this lack of personal contribution by therapists. Why are there so few articles with personal contributions in relation to this process?

I have speculated that the lack of stories suggests that most therapists have sorted out their lives to perfection and come from very healthy families. But my literature search has provided significant evidence to the contrary – therapists often come from dysfunctional families, and a significant number of therapists have experienced marital and personal difficulties (Miller, 1981; Racusin, Abramowitz & Winter, 1981; Sussman, 1992).

The other possible explanation is that we engage in the somewhat dishonest practice of using our professional capacity to focus on the patients' side of things while avoiding self-reflection on our own "participation". This process parallels the process where a family insists that the only problem in the family is the identified patient. Therapists may rationalise their failures by labelling patients as difficult or resistant (Noonan, 1999) and assuming that for the process to move, it is just the patient who has to shift. When therapists experience lack of progress, the responsibility for failure seems, regardless of the therapeutic orientation, to lie with the "client's inability" (Spellman & Harper, 1996). Therapists may fail to examine and understand how their own reactions are affecting the process, and which may lead to resistance or termination (Noonan, 1999).

The old paradigm, with the therapist in the observer position, laid all the blame at the feet of the patient. However, within a paradigm where therapist and patient co-create the therapeutic process it is implicit that they co-create the stuckness (Darwin, 1999). Hoffman (1993) describes her self-disclosure in respect of the parallel position between herself and a client, the mother of an estranged daughter. She pointed out to her client that, because of her own issues, she might push the client too hard to make peace with her daughter. Discussing further connections between "resistant clients" and the therapist's story, she says:

I stepped back and reflected on what "story" of my own could have been influencing me and shared that reflection. In former days, I would have defined the couple as "resisting" me and I would probably have thought up some counteracting manoeuvre. I would not have paid attention to my feelings. I particularly would not have discussed my plight with regard to my own daughters. (p. 73)

In the battle between patients and therapists it may be the patient who becomes the scapegoat for our own professional failures.

When therapy is about “expert knowledge”, power is evoked and the therapist is consequently blind to the experience in the room (Amundson, Stewart & Valentine, 1993). The therapist’s position of expertise may foster what Amundson et al. call a “colonial discourse”, which may compromise her flexibility and create a “resistant” client. When we embrace curiosity and ambiguity instead of a position of power, we join a process that opens a space for our own vulnerability. When we consider therapy as an egalitarian process for therapist and client alike, we move to a model where the therapist’s use of self means being willing to expose her struggles and make herself vulnerable, to the therapeutic advantage of her client (Prosky, 1996).

Experiencing or sharing vulnerability has never been a strong point in the medical profession because medical training discourages professionals from sharing their vulnerability (William, 1992). Nevertheless, I believed that psychotherapists (including myself) were definitely different.

It was therefore with disappointment that I discovered the parallel: just as medical professionals protect their vulnerability by using the power of medicine and a hierarchical communication frame, so we therapists protect our vulnerability by using the power of interventions, and neutrality. In both, it is the position of the expert that maintains the power difference that protects the expert. Hoffman (1993) reflecting on the issue of being an “expert”, notes:

When I stopped being an “expert”, I also became less distant and less anonymous. I will now share a much more private side of myself, and I will admit error if I think I have been wrong. So many models of family therapy have kept therapists standing on a mountain-top or hidden behind a screen. (p. 73)

There is a general assumption that the client’s growth is the priority in the therapeutic process and that making space for the therapist’s growth may even negatively interfere with the client’s progress (Baldwin, 1987). Nevertheless, this assumption may serve as protective shield for maintaining the expert role and the perception of the therapist as objective and perfect, and as someone who has completed her personal growth. I cannot help wondering just how often that perception matches the reality.

A psychotherapeutic relationship in which growth is unilateral promotes and maintains the power difference in the relationship. When psychotherapy is viewed as a shared co-creation there are implications for both client and therapist. In terms of the constructionist paradigm, we cannot not use self in therapy (David & Erickson, 1990), and not acknowledging in what way we use the self is a dishonest practice which is damaging to therapists and ultimately to our clients. Through my own experience, I learnt that, when we participate in a client's change, we need to be aware of the possibility that the process will affect us and change us too (Viney, 1990). Unless the therapeutic process is therapeutic for both sides, the growth is restricted, and the therapist who stagnates invariably restricts her client's growth. If the therapist is ready to let go of the "expert role", this new position might provide the potential for reciprocal growth. Under these terms we can be sure, as Atkinson and Heath (1990) suggest, that therapy can become at least useful, if not enjoyable, for both the client and therapist as it creates challenges for both sides.

The lack of personal evidence about shifting from first to second-order cybernetics inspired my decision to describe not just my patients' process but my own shifts and the tremendous impact they had on my work and my personal life. I discovered – "on my skin" – how different a second-order role is. Participation created a transformation from a self-deceptive position (Polonoff, 1987) to a real-self position (St. John, 1987). In this process I learnt to risk being my real self, with all its positive and negative characteristics, and this acceptance created a tolerance for other realities which may be very different from mine. This development led to fewer defensive reactions to clients and situations which would probably have provoked a reactive response from me before.

## OVERVIEW

I begin with the theoretical context of cybernetics and constructivism and move into describing first-order and second-order cybernetics. In the second chapter I look at systems theory and the post-modern paradigm, and their relevance to our understanding of reality. Then I look at language from a post-modern perspective, not as just a reflection of our reality, but as a separate entity. The third chapter investigates relevant perspectives on the qualitative research methodology used in this thesis. It also discusses social research and its meaning in respect of participation, a self-reflective stance, emerging subjectivity and emotional issues. Finally, the chapter discusses the aim and design of the research undertaken.

The position of “first order” in relation to both the therapist and the group is explored in the fourth chapter. First I examine how I, as the therapist, created my “expert” position by improving my knowledge of illness, compliance, medical language, and issues important for working in the medical context. I assumed that the knowledge I acquired would prove not just necessary but sufficient for improving medical compliance. Initially, my focus in working with the group was on psycho-education and compliance issues. I go on to consider the group process, and members’ focus on the medical system. In each perspective, the therapist’s (mine) and the group’s, there was an exclusion of self and an approach that designated the problems as being “out there”. Thus when confronted by lack of progress in respect of compliance and my own stuckness in the “first order” position, I initially claimed no responsibility for the process and maintained my focus “outside” – on the “resistance” of the thalassaemia group. The chapter then recounts a very similar parallel process with the thalassaemia groups where the focus was on systems “outside”, such as the medical staff system. The last part of the fourth chapter examines how the expert stance led to stuckness and, from there, to my facing my fear of inadequacy and professional failure. This confrontation with failure triggered various uncomfortable feelings and subsequently led to an exploration of my personal history.

In the fifth chapter I look at autobiographical components relevant to my personal and professional selves in different contexts, such as country of origin,

family of origin, significant others, training and professional development and my marriage. A therapist's own family is the incubator for her development of relationship skills. Her capacity to be comfortable in different and at times complex relationships may be vital for positive psychotherapy outcomes (Winter & Aponte, 1987). The degree of resolution in her personal life will improve the way she manages her personal reactions to unresolved issues so that, instead of being destructive, these issues will be more likely to benefit her clients (Winter & Aponte, 1987). It may therefore be vital for the therapist's professional effectiveness to get to know her real self. Bruner (1987) states:

I cannot imagine a more important psychological research project than one that addresses itself to the development of autobiography – how our way of telling about ourselves changes, and how these accounts come to take control of our ways of life. Yet, I know of not a single comprehensive study on this subject. (p. 15)

Lack of progress initiated a self-reflective process on my part, and led to a significant shift from a first-order to a second-order position. In the sixth chapter I explore those perturbations and the emerging connections between my professional and personal selves. The most significant process for the shift from the first-order to the second-order position was deconstruction of the expert stance. Fear of professional incompetence and failure promoted painful perturbations for me, both professionally and personally. Self-reflection created a space for the inclusion of my self, which shifted my focus from the group and their "resistance" to my "handicaps" (Haber, 1990). In this chapter I describe the development of the second-order stance through 5 years of work on my personal and professional selves. I examine the use of self and self-disclosure in relation to the inclusion of myself in terms of the second-order stance. Parallel to this process, the group conversations shifted to very personal and emotional themes, bringing members to a sharper awareness of themselves.

Chapter 7 investigates my personal and professional transformation, which led to a greater integration of my professional and personal selves and enhanced my professional competence. I examine the interface between these two selves and subsequent changes triggered by this process. I explore shifts in the group process, which resulted in greater effectiveness in handling the illness and improved compliance. Our stories become an example of the post-modern notion of the mutual

construction of narrative, where therapeutic process becomes a pursuit with both client and therapist's narratives perturbed and changed in the process.

Chapter 8 explores the theoretical and practical implications of this research. I examine the characteristics of the first-order and the second-order therapist. The two positions are seen, not as opposed to each other, but rather as reflecting two different stages in therapeutic development. This research concludes that a second-order stance is a position that one develops through complex, multifactor professional and personal life experiences and transformations. Second-order change – or a fundamental change of one's basic concepts – is perceived as necessary for the development of a second-order stance. I look at concepts such as power, knowledge, understanding, change and the personal self of the therapist in relation to the therapist's development from first-order to second-order therapy.

Finally, I investigate the consequences of this developmental process for training, supervision, and continuing education. I examine the process of teaching and methods that reflect the first-order and second-order positions. Development of the second-order position, which promotes inclusion of the self of the therapist, requires a significant shift, from focusing solely on the professional self to developing contexts that promote personal growth and lead to a greater integration of the professional and personal selves of the therapist. I contend that our training, supervision and continuing education should address the use of self and the family of origin. Self-analysis and personal therapy are seen as contexts for promoting professional effectiveness.

Discovering one's real self (St. John, 1987) means facing up to one's personal and professional handicaps. This might be an excruciating and difficult process, but it can contribute greatly to increasing the ability to make "handy capable" responses (Haber, 1990), rather than remaining stuck in one's "handicaps". In that process we must be aware that our clients can teach us lessons that may have a profound effect on our professional and personal selves (Bugental, 1991).

## CHAPTER 2

### THEORETICAL CONTEXT

#### Paradigm Shift

Most of us were socialised in a world that adhered to philosophical assumptions rooted in the Western, scientific tradition. We have all been taught to think in linear, cause/effect terms, whereby event A causes event B in a linear fashion and A must therefore be held responsible for what happens to B.

We also have been taught that the world we see consists of subjects and objects, and that there is a reality that exists outside of our own minds. Meaning therefore derives from external experiences of which we are the recipients. We understand the world in terms of deterministic principles, which signify that there is a possibility of discovering the absolute truth about reality (Becvar & Becvar, 1996).

The scientific tradition uses an appropriate empirical, quantitative scientific methodology. The results of scientific research are held to be measurable and objective, an assumption that generates further theories about reality as being either this or that, and explanations of it as being either right or wrong (Becvar & Becvar, 1996). In psychology, the belief in individualism was based on this tradition, with behavioural scientists embracing the notion that mind and reality exist independently of one another. Psychologists gained credibility by their acceptance of the importance of objectivity and the value of measurable, quantifiable data. Within this tradition, psychodynamic theory, with its emphasis on the individual and its assumption of a reality outside of our minds, was acceptable.

The kind of thinking I have described is all part of the positivist paradigm, which dominated the scientific field, including psychology, from the mid-eighteenth century. "Paradigm" refers to "thinking about thinking" or "a subset of rules that define a particular segment of reality" (Auerswald, 1985, p. 1), and one characteristic of this paradigm is that positivists believed in the role of the scientist as an ~~active~~ observer (Lincoln & Guba, 1985). The idea of the scientist as a separate entity from that which he or she is observing was only challenged in the post-positivism era of the twentieth century, when the positivist assumption of an objective observer free of

subjective biases shifted to the post-positivist or post-modern view of the observer as constructing reality (Lincoln & Guba, 1985).

Systems theory ushered in the shift from the positivist paradigm by moving away from linear cause/effect thinking and proposing a reciprocal or circular causality. The concept of circularity, developed by Bateson (1972), whereby systems are seen as circularly organised and circularly interconnected with larger systems (Dell, 1982), ultimately replaced the concept of linear, cause and effect causality. Fish (1990) has subsequently criticised exclusive adherence to either a recursive or a circular view of causality and suggests that this does not arise from any deficiency of the systemic paradigm but from an incorrect and partial understanding of those concepts by Bateson and his followers. He points out that Bateson's rejection of linear causality was based on a false dichotomy, and that neither the circular nor the linear view of causality should be regarded as incorrect but simply as representing different perspectives.

Systems theory paid less attention to the individual and more to relationships and the patterns of relationships. At the same time, attention moved from the observed to the observer, making subjectivity inevitable, as the observer perceives, acts and creates her own reality (Becvar & Becvar, 1996). Systems theory embraces a holistic perspective, which takes into account the context of interaction. Hence, interaction is seen as a dialectical process in which the parties have a mutual influence on one another and therefore share responsibility for what happens in the interaction.

The concept of reality as a construction is central to the theory of social constructionism. This approach, which emerged from the field of psychology, expands the idea of subjective reality and holds that the world we see is only a view, it is our description of the world (Keeney, 1983). The focus now moves to the interaction between the therapist's subjective experience and that of the client, emphasising the reciprocal, mutual influences in the psychotherapeutic process (Bowles, 1999).

The therapist's stance changes from that of neutral observer to one where she is aware of her own subjectivity and is tolerant of "not-knowing" (Darwin, 1999). The therapeutic process becomes an interactional, intersubjective experience in

which therapist and patient co-create any stuckness that arises in the interaction. There is a shift from the objective paradigm to a paradigm of multiple realities, and a shift from the traditional epistemology to a socially constructed epistemology. As we move from paradigm to epistemology we move to a “paradigm of paradigms”, where the term “epistemology” is used as a supraordinate term to “paradigm” (Simon, Stierlin & Wynne, 1985, p. 114).

### Ontology/Epistemology

Ontology refers to the nature of “reality”, and it is noteworthy that, as Guba (1990) points out, the ontology of positivism is realism, whereas the ontology of post-positivism is critical realism, which assumes that reality cannot be fully apprehended because of inherent limitations in human perception and cognition. Social constructionism relates to the ontology of relativism, which implies that realities are multiple and that the ultimate truth of these multiple constructions of reality cannot be determined. Realism implies that the therapist knows the truth and is an expert who can remain neutral and objective, while post-modern ontology positions the therapist in relativism and multiple realities.

The word “epistemology” comes from the Greek *episteme*, which means theory of knowledge. As a science, epistemology investigates how organisms think and arrive at decisions which determine behaviour (Bateson, 1979). According to Dell (1982), epistemology is the branch of philosophy that investigates the origin, nature and limitations of knowledge. He points out that therapists often use the term “epistemology”, not as referring to a theory of knowledge, but as a kind of synonym for “paradigm” or “world view”. Auerswald (1985) defines epistemology as “the rules used in thought by large groups of people to define reality” (p. 1) and calls it the paradigm of paradigms. For Guba (1990), epistemology refers to the relationship between the knower and the knowable and lies along a continuum from subjectivism to objectivism.

Objectivism relates to what Guba (1990) refers to as a positivist epistemology, in which the observer remains separate from the observed and can be bias-free. He refers to post-positivist epistemology as a modified objectivism where absolute objectivity is impossible because of the tendency of the observer to

influence observed reality and the inability of the observer to be wholly separate from the observed. Finally, says Guba (1990), in constructivism (defined below) the epistemology is subjectivism, in which “inquirer and inquired are fused into a single (monistic) entity” (p. 27). Instead of one objective universe, we have what Maturana calls a “multiverse”, where many observers’ “verses” exist, each valid in its own right (Efran & Lukens, 1985, p. 25). 1/5

Intersubjectivity reflects a post-modern epistemological move from objectivity and the scientific method to a relational context. The concept of intersubjectivity has led to a rethinking of the scientific method as a final arbiter of truth. It further challenges the idea of therapeutic objectivity and considers how client and therapist’s inner subjective lives interact with and create one another (Berzoff & de Lourdes Mattei, 1999). In this context, the therapist cannot *not* use his or her self in therapy (David & Erickson, 1990). Thus the issue of the therapist’s awareness of the self and of the constructive use of self, along with training in relation to the self, have become significant questions (Berzoff & de Lourdes Mattei, 1999).

In the traditional, positivist era we used to rely on the power of science and the knowledge of objective experts, and the role of the therapist has therefore been that of a social engineer. However, in the more recent era of post-modernism, the possibility of absolute truth and objective knowledge was challenged on many fronts. In addition, science has been criticised as undervaluing the role of the mind in all meaning-making, while the importance of language as a socially constructed system through which we come to know and understand our world has been probed.

Constructivism is one of the theories that challenged the objective paradigm by claiming that reality is no more than our construction of reality and that there is no reality that is an absolute truth or that is more objective than any other.

### Constructivism

Traditional epistemologies view cognition as mirroring a reality that exists independently of the observer. Constructivism, on the other hand, does not aim at knowing reality but seeks to understand the way we construct multiple and diverse

realities (Simon et al., 1985). This requires us to change from an “observed system” reality with the notion of knowing the objective truth, to an “observing system” reality with the notion that we can only know our own construction of reality (Hoffman, 1988).

Radical constructivism is radical because “it breaks with convention and develops a theory of knowledge in which knowledge does not reflect an ‘objective’ ontological reality, but exclusively an ordering and organisation of a world constituted by our experience” (von Glasersfeld, 1984, p. 24). This kind of knowledge of reality clearly cannot tell us anything about the world beyond our experience. With this point of departure, it is not possible to match our perceptions with reality; rather we look at how our perceptions fit into our environment. The world we experience is the way it is because of the way we construct it together. Reality gets constructed without our awareness of the act of creating, and it appears as if given by an independent “existing” world (von Glasersfeld, 1984).

Constructivism shifts from searching for reality to looking at our construction of reality, which implies that there are multiple realities. The mode of observing changes the observation in irreversible ways and consequently what we know is about the construction of an observer (von Foerster, 1984). As each of us lives in and creates reality in a different manner, our reality is equally true for each of us. From this perspective we can no longer talk of a universe but rather of a multiverse of many equally valid observer-dependent realities (Becvar & Becvar, 1996).

In the process of observing, we invent our reality and thus it becomes important to understand the assumptions according to which we construct our reality. For constructivists, “the entire therapeutic venture is fundamentally an exercise in ethics – it involves the inventing, shaping, and reformulating of codes for living together” (Efran, Lukens & Lukens, 1988, p. 270).

Therapy thus becomes a dialogue that facilitates the accommodation of the needs and desires of all the participants (Becvar & Becvar, 1996). Speed (1991) argues that constructivist ideas have been valuable in challenging the all too frequently held assumptions of helping professionals that their particular model or theory is the truth and the only truth. However, she criticises constructivism for going too far and suggesting that reality has no relevance at all to what we know.

Speed (1991) proposes an epistemological stance called co-constructivism, which takes the view that what we know happens in the relationship between the knower and the known. This approach regards reality as constructed according to the ideas generated by individuals or groups. According to Speed, this stance has two implications for clinical practice. First, there is the responsibility we should exercise in becoming more aware of how our ideas determine what we see. Second, we should do more empirical research to investigate reality, which partially determines what we know. Speed pointed out that just because we filter reality through our perceptions does not mean that reality does not exist. Further, she adds that although understanding human behaviour may be a complex task we should not abandon the hope of knowing our reality.

Social constructionism understands reality as a construction that functions in relation to the belief system we bring into a particular situation and according to which we operate. The context in which we create meaning thus becomes a crucial component. Social constructionism introduces the idea that meaning is formed in interactions, with the use of language and within a specific context. The post-modern stance understands that the self is not isolated but is constructed in relationships (Becvar & Becvar, 1996), while social constructionism holds the view that knowledge, including scientific fact, is a construction of mind in the social domain (Goolishian & Winderman, 1988).

Social constructionism and post-modernism in general challenge the hierarchical position of the expert with her privileged information, hence power. From the new perspectives, client and therapist are equally engaged as co-creators of a shared reality. In fact, says Noonan (1999), therapists, like their clients, bring their own personality, ways of relating and affective needs into the therapeutic endeavour. Gergen (1985) notes that “all ideologies, values and social institutions are man made” (p. 270).

Therapy, seen through the eyes of the social constructionist, is described as co-creating meaning while all parties participate in the interactive exchange. The social constructionist perspective dramatically changes the role of the therapist from that of the expert, objective observer to that of participant. Meaning is co-created in a recursive process of mutual participation between the client and the therapist.

Hoffman (1988, pp. 124-127) summarises several points relating to constructivism and clinical practice:

1. There is no belief in an objective reality, which carries more implications, rather than fewer, for acting in terms of the therapist's conscience.
2. There is shift in focus from behaviour to idea, which means a shift from intrapsychic systems to interactional systems
3. The problem creates a "system", so therapy is a space where people have a conversation about the problem and where therapy is described as narrative.
4. The therapist does not adopt any kind of meta position because we construct our reality, therefore we can never find an outside place from which to look at it.
5. The therapist sides with everybody in an effort to find the meaning behind events.
6. There is a relative absence of hierarchy with an increased tendency towards self-disclosure.
7. There is much less focus on issues of power and control (the fashionable word is "empowerment").
8. The concept of position in respect of what one can see and think or do depends on where one stands. In order to get a sense of the validity of different perspectives, one has to have clear boundaries.
9. There is a tendency to inhibit intentionality where we create a context in which change may come about "unawares".

Hoffman (1988) understands therapy as a mutual system of influence. This creates a space for a change in the therapist's construction of reality. The therapist's inclusion in the wider system generates a need for self-reflection. Thus the therapist should remain aware of how her construction of reality affects the client's construction of reality.

Dell (1982) observes that "speaking about experience or reporting experience can only be a reflection upon or a representation of experience" (p. 57). He argues that there are fundamental differences between our experience, our description of experience (which allows us to represent our experience to others), and our explanation of the experience (which is meta not only to experience but to description as well). Explanation relates to the cause or reason for the experience we describe. Dell notes, too, that every therapeutic intervention is embedded in the circular interaction between the family and the therapist.

There is thus no objective reality and consequently our awareness of the value-based nature of human activity is inevitably a personal responsibility (Keeney,

1983). This implies that, in the therapeutic process, the therapist should take responsibility for exploring and understanding the impact of her epistemology on the therapeutic process. Constructivism moves away from a strongly instrumental, goal-oriented approach to a definition of therapy as a conversation that generates new meaning and understanding (Anderson & Goolishian, 1988).

Constructivist ideas and the post-modern paradigm have had a significant influence on the psychoanalytic perspective. In traditional psychoanalysis, the analyst deals with one subjectivity – that of the client – and this process is called transference. The concept of neutrality in psychoanalysis means that the therapist should present a blank screen, as it were, even though it inevitably gets contaminated with the therapist's feelings – a process called counter-transference. When those feelings arise, the therapist is obliged to cleanse himself through his own analysis to ensure the patient's centrality as the main focus (Berzoff & de Lourdes Mattei, 1999). The attempt to remain aloof and always in control was criticised as presenting an unrealistic model for patients, and because it increases the possibility that the analyst will lose touch with her real self (Maroda, 1999). Today the analyst's neutrality is no longer a desired goal. The post-modern stance challenges the belief that absolute truth exists. This position creates the need for the therapist's knowledge and power to be deconstructed in a way that permits greater spontaneity and mutuality, say Berzoff and de Lourdes Mattei (1999). They note that the therapeutic process should reflect the analyst's personal history and characteristics, not just the patient's.

Constructivism changed the notion of the expert-therapist and the assumption that it is the client's problems that need correcting. The therapeutic process now becomes a fit between the therapist's construction and that of the client. The idea of a shared construction intrudes on the therapist's comfort zone in that it overturns the assumption that only the client's perspective needs to change. With the concept of mutuality comes inclusion of the possibility that the therapist's constructions might be changed and, as Darwin (1999) remarks, we must be prepared to have the courage to risk what we ask our clients to risk – change. Prosky (1996) goes even further, saying that to be effective with clients in this way, we as therapists need to use not

just our professionally defined selves, which are restricted to safeguarded versions of ourselves, but our whole and best selves.

Thus the therapeutic process needs to reflect on the clinician's own personality and history, not only on the patient's. Reflecting critically on one's own co-participation process, says Hoffman (1992), allows reciprocal shifts in both client and therapist, while Anolli (1987) believes that exploring one's behaviour and relational patterns greatly enhances a therapist's professional flexibility and effectiveness.

Twenty years ago, constructivists proposed that, to understand interactional systems, they had to be described rather than explained. With this change in emphasis, it has been suggested that descriptions of our reality provide information about the observer rather than about the observed. While acknowledging the difficulties of understanding what is it that we see from what we know, Golann (1987) suggests the use of representational description to achieve a disciplined use of subjectivity. Descriptions, in contrast with explanations, relate to a position of multiple realities and the stance that anyone's description is as good as any other, as it is no more than a reflection of the individual's own reality. We can neither speak about, nor report, our experience except from within the domain of experience. So when we speak about our experience, it is a reflection or representation of experience (Dell, 1982). Golann (1987) notes that this constructivist perspective has been also associated with second-order cybernetics or the cybernetics of cybernetics.

### First and Second-Order Cybernetics

The theory of cybernetics (or systems theory) grew out of communication engineering and computer science. Its main principles relate to understanding how systems of all kinds are regulated. First-order cybernetics is based on the general assumption that the system being observed is separate from the observer, while second-order cybernetics involves the meta step of including the observer (Sluzki, 1985). In second-order cybernetics, reality is no longer conceived of as an entity separate from the observer but is, instead, understood as dependent on the observer's way of organising reality. Sluzki states that this "new" cybernetics includes the observer's role in constructing the reality being observed. He differentiates between

the first and the second waves, and explains that the first wave focuses on how systems maintain their organisation. The main concepts relate to homeostasis, rules and self-correction. The second wave, according to Sluzki, focuses on how systems change their organisation, and works with concepts such as recursiveness, self-reflective process, complexity and autonomy.

Becvar and Becvar (1996) speak of first and second-order cybernetics as simple cybernetics and the cybernetics of cybernetics. They use the metaphor of the black box to describe how, in simple cybernetics, the observer takes a position outside of what is going on inside the system. From the perspective of first-order cybernetics, the therapeutic stance still sees reality as “out there”, something we can observe without ourselves being influenced by it.



Figure 2.1 Simple Cybernetics. From “*Family therapy: A systemic integration,*” by D.S. Becvar and R. Becvar, 1996, p. 76.

Becvar and Becvar (1996) define a number of the concepts that form part of the simple cybernetics approach, as follows:

1. Feedback is a process whereby information about our past actions is fed back into the system. Positive feedback is the acknowledgement that the change has occurred, while negative feedback indicates that the status quo has been maintained.

2. Morphostasis and morphogenesis refer to a system’s ability to remain stable in the context of change or to change in the context of stability. Morphostasis refers to the system’s tendency towards stability while morphogenesis refers to its tendency towards change and growth.

3. The rules of the system express the values of the system as well as the roles that are appropriate within the system. The concept of boundaries implies the notion of a hierarchy within the system as well as between systems.

4. Openness and closedness relate to the extent to which a system permits the input of new information into the system.

5. Entropy refers to a position where a system is either too open or too closed, resulting in a tendency towards maximum disorder or disintegration. On the other hand, when the appropriate balance has been maintained between openness and closedness, we may say that the system is in the state of negative entropy or negentropy.

6. Equifinality is the tendency of systems to achieve the same result although the starting position varies. By contrast, equipotentiality reminds us that different final states can be derived from the same starting point.

Communication and information processing are the most important concepts in systemic thinking. The three basic principles of communication (Becvar & Becvar, 1996) are:

1. One cannot not behave – which means that even “doing nothing” is doing something.
2. One cannot not communicate – even sitting silently conveys some message to an observer.
3. The meaning of any behaviour is only a personal meaning – no more or less correct than any other.

At the level of the cybernetics of cybernetics, all communication is self-referential, which means it is based on our own epistemological premises. Becvar and Becvar (1996) define some of the characteristics of the cybernetics of cybernetics as follows:

1. In respect of openness and closedness, the cybernetics of cybernetics talks of perturbations rather than inputs, and the black box metaphor is replaced by a view of the system and the observer as mutually interacting.
2. Autopoiesis refers to the way different parts of the system relate, and the being and doing are inseparable.
3. Structural determinism relates to the process whereby the system itself determines the range of structural variations. Thus the system is limited by its own structure in respect to what it can or cannot do.
4. Structural coupling provides organisms with the means to survive by fitting with one another. How they interact is through a recursive process of mutual influence determined by the structure of the respective systems. Therefore, change is the responsibility of both systems.
5. The epistemology of participation reflects the focus on how the observer and the observed are connected to one another.
6. Reality is generated as a construction of multiple individual realities, therefore we are talking of a multiverse instead of a universe, each with a personal meaning as valid as any other.

Hoffman (1985) points out that the shift from a first to a second-order approach has the following characteristics:

1. inclusion of the therapist's own context
2. collaborative instead of hierarchical approach
3. focus on context for change rather than specifying a change
4. avoiding instrumentality
5. “circular” assessment of the problem
6. non-judgmental approach. (p. 395)

Second-order cybernetics, or the cybernetics of cybernetics, considers the observer as part of the observed. Accordingly, say Becvar and Becvar (1996), the therapist works with his or her own perceptions and constructions as well as with those of the client. The therapist who fails to acknowledge personal membership in the context within which a family exists and its problems are defined, and therefore simply treats families, operates no differently from the therapist who chooses to see problems as residing in the mind of individuals, and therefore treats patients (Becvar & Becvar, 1996, p. 79).

From the perspective of first-order cybernetics, we still think of reality as “out there” – something we can observe without influencing what we observe while we observe. Thus the therapist’s role is to discover and treat the problem, and change the system. On the other hand, as Becvar and Becvar (1996) indicate, second-order cybernetics considers the observer as part of the observed. Reality is self-referential and interaction between the therapist and client is seen as recursive perturbation. According to Becvar and Becvar, the epistemology of participation is a main principle of second-order cybernetics, therefore the focus is on “how the observer and the observed are bound up with one another” (p. 81). Consequently, it becomes very important to understand those assumptions and presuppositions of the therapist that determine her or his way of constructing reality.

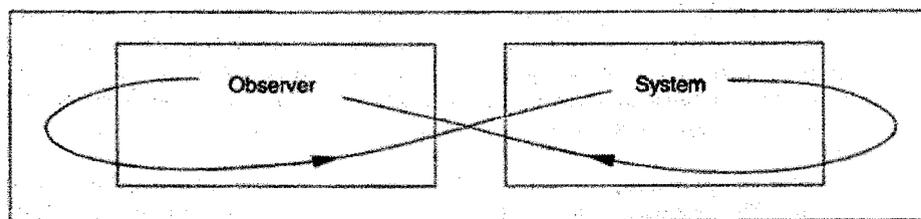


Figure 2.2 The cybernetics of cybernetics. From “*Family therapy: A systemic integration*,” by D.S. Becvar and R. Becvar, 1996, p. 76.

As Efran and Lukens (1985) note, “it is arrogant of us to think that we ‘control’ other people’s lives” (p. 72). Clients “buy” what they want, not what we want them to “buy” and, as Maturana points out, sometimes it is wiser to start by asking clients what they want to conserve, rather than what they want to change (Efran & Lukens, 1985). Adopting Maturana’s point of view, say Efran and Lukens, means that “we have to begin thinking of ourselves more humbly as participants who have been invited to co-drift with members of families rather than ‘change agents’

(p. 74). They go on to make the point that psychotherapy is therefore not a “treatment” that we apply to a passive organism. Families do not change in the therapist’s office, rather they are always changing and a visit to the therapist is just one of the steps in that process. From the client’s perspective, therapy “is a medium in which to pursue particular kinds of ‘conversations’ – to which the therapist is invited” (p. 72).

The first-order therapist follows a hierarchical, expert-oriented approach, which revolves around interventions and goals. The second-order therapist, on the other hand, uses a collaborative, non-judgmental approach which includes her or his own context (Hoffman, 1985). A collaborative process in therapy creates a space in which all participants, including the therapist, can be open to change (Anderson & Goolishian, 1988). Participation, process and mutual influence are consistent with second-order therapy (Becvar & Becvar, 1996). There is, in addition, no prescribed form that therapy must take. Instead, the basic limitation for acceptable practice lies within the bounds of ethical practice.

Second-order practice confronts us with the limits of what we can know, and with the idea that we cannot go beyond the limit set by our own minds. In a second-order process we are more likely to acknowledge the mutual influence of the individuals interacting, “whereby each transforms the other by being in relationship” (Becvar & Becvar, 1996, p. 335). Mutual influence implies a need for continual reflexivity. Indeed, the therapist’s self-reflexivity is intrinsic to the post-modern stance with its views on therapists’ subjectivity and participant mode. The therapist should therefore observe how her emotional and cognitive constructions create and interweave with the client’s constructions.

Speaking of the difference between first and second-order views, Hoffman (1985) describes the first-order therapist as thinking of himself as an environmental engineer trying to change the course of a river, while a second-order therapist is like a white-water canoeist navigating a river. According to Hoffman (1993), second order is not better – “just more inclusive” (p. 75). She concludes that a second-order view means “therapists include themselves as part of what must change” (p. 92).

For Amundson et al. (1993), a first-order perspective favours a “therapy of power” while a second-order position is a “therapy of empowerment”. The group of

therapists who originally adopted a first-order position advocated power as an integral part of human relationships, including therapeutic relationships. First-order therapists remain in the expert position while second-order therapists shift to a non-hierarchical position equal to that of their clients.

The first-order therapist often uses strategies and interventions that promote an imbalance of between the therapist and the family's systems and maintain the expert, most powerful position as part of the therapist's role. The second-order therapist is somewhat uncomfortable in that position of power, claiming that therapists should remain in the not-knowing position (Goolishian & Anderson, 1992). The first-order therapist tends to occupy the expert position, needs structure and clarity, may tend to rescue clients and foster dependence, and when frustrated may use less therapeutic variety. The second-order therapist, by contrast, can tolerate ambiguity, can remain curious and flexible when frustrated, tends to be collaborative and fosters a sense of self-competence in the client (Amundson et. al., 1993).

Within the therapeutic system, change can take place on a number of levels. Depending on whether the level is quantitative or qualitative, we talk of first and second-order change. First-order change refers to corrective changes based on negative feedback that balance out deviations but leave the system unchanged. Second-order change is based on positive feedback and thus initiates change in the structure of the system and the development of new structures (Simon et al., 1985).

If we describe perception as a process of construction, it is important to understand the presuppositions and assumptions according to which therapists construct their reality. Accordingly, therapists should be aware that what they work with are perceptions and constructions, both their own and those of their clients. We do not need to make either/or choices, but can think in terms of both as an integral part of a complementarity comprising a larger whole. In that process language, as the means whereby we convey our constructions, becomes an important entity. Discourse is then a central concept in terms of which language can expand or oppress (Becvar & Becvar, 1996). We experience and express our meaning through a system of language, which cannot be separated from the system of our community.

Our lives are shaped by the stories that we live and tell and our experience is, in turn, textured by the stories we tell. In our interactions, we express what we experience and know through a system of language that has a separate existence. Accordingly, we live within the values and ideologies of our own language system.

Stories that are self-reflective initiate self-awareness, which gives legitimacy, perspective and reality to our life (Mair, 1990). Psychology may therefore be seen as a story-telling discipline and the psychologist as a story-teller. We express ourselves in language, but language speaks of us. Mair points out that at the therapy level we need to be aware that self-involvement is inevitable, and that our personal meaning is immersed in our language.

Second-order cybernetics has placed language in the spotlight as a crucial component of the therapeutic process, and the literature abounds with discussions of the language we use. Our language and the words we use have multiple meanings and alternative interpretations, leaving texts open for more than any given single reading. The second-order communication process is based on three premises: (a) that one cannot not communicate; (b) that one cannot not behave; and (c) that a given behaviour has no true meaning, only a personal meaning.

Anderson and Goolishian (1988) use the term “being in language” to refer to the process of the social creation of the intersubjective realities that humans share temporarily with each other. According to them, the therapeutic system is a “linguistic system” (p. 373), which is a two-way exchange and where the role of the therapist is in creating and facilitating a dialogical conversation. Social systems communicate through language, and all problems are in language (Efran & Lukens, 1985). Problems are a form of co-evolved meaning that exists in ongoing dialogical communication. Anderson and Goolishian (1988) hold that problems are in the intersubjective minds of all who are in active communicative exchange and, as such, are themselves always changing. They provide the following guidelines in respect of language:

1. The therapist’s inquiry should be respectful of the parameters of the problem as described by the client. The therapist stays close to the understanding of the moment, and eases outside of those parameters slowly.

2. The therapist shows respect for all ideas demonstrated and at the same time facilitates mutual inquiry about familiar ideas, consequently broadening them and creating new meaning.

3. The therapist's language has to be cooperative, which moves the interview towards collaborative conversation.

4. The therapist should converse in the client's language.

5. The therapist should not try to understand too soon, since it carries a risk of blocking the development of new meaning and could lead to misunderstanding.

6. The therapist's questions are aimed at creating a mutual inquiry and discussion in which the therapist develops the art of questioning that is not aimed at discovering information or collecting data.

7. The therapist takes responsibility in creating a context which will facilitate the expansion of multiple realities and generate new meaning.

8. The therapist should be able to maintain multiple views within himself or herself and should avoid "owning" one specific view or idea.

Therapy is a process of expanding and saying the "unsaid", thus the resources lie in the "circle of the unexpressed" (Anderson & Goolishian, 1988, p. 381). According to these authors the capacity for change is to be found in our ability "to be in language" (p. 381) with each other and develop new themes and new stories. When therapists and clients start therapy, each uses different language, but shared language may occur as therapy progresses (Viney, 1990). Creating a shared medical narrative may be particularly significant for therapists working in a medical context. Ultimately such a process creates space for common humanity and healing (Stein, 1990). Anderson and Goolishian see the therapist as an architect of dialogue who is responsible for making room for dialogical conversations. They see prejudices as opportunities, and the therapist should be ready to risk entertaining alternative positions and meanings. Thus therapists must be able to let go of old meanings, just as we expect our clients to do. This process of change ideally never stops, even for the most mature therapists (Viney, 1990).

Through the stories we tell we also invent ourselves with others (Penn & Frankfurt, 1994). These life stories are susceptible to cultural, linguistic and interpersonal influences (Bruner, 1987). Events that have occurred in one time will be narrated at another, and written in a third. Each time, the author reconstructs and re-experiences her story, developing a richer and more complex narrative as the telling proceeds (Penn & Frankfurt, 1994). As a result we create different versions of our stories, and different scenarios (Bruner, 1987).

With regard to my own language, the process of producing this thesis has been pervaded with anxiety about my competence to write in a foreign language. I was also concerned about the reader's boredom often experienced by research readers (Garner, 1991), and I experienced further anxiety in attempting to avoid a style of writing that makes the content incomprehensible to lay readers. This kind of writing characteristically does not use a personal voice and is written in an elitist fashion (Garner, 1991).

Finding a personal voice and a style that does not promote boredom or elitism required a consideration of various factors. The combination of a confessional and an impressionist style creates a personal voice for tracking the connections between the personal and professional selves in different contexts. The confessional style focuses "far more on the fieldworker than on the cultures studied" (Van Maanen, 1988, p. 45), and I used this style for my narrative in order to create the shift from reader/observer to reader/participant. As part of the visual documentation, I used photographs of the children, their parents, myself and my family, together with drawings done by the children, in order to promote the feeling of "being in the other person's shoes".

Witnessing the emotional component of my story may initiate multiple connections for the reader, to whom it may even bring change (Penn & Frankfurt, 1994).

## CHAPTER 3

### METHODOLOGICAL PERSPECTIVES IN QUALITATIVE RESEARCH

#### Introduction

Bogdan and Taylor (1975) define methodology as “the processes, principles and procedures by which we approach problems and seek answers” (p. 1). Most research is implemented at the level of first-order cybernetics in that phenomena are regarded as being out there and the observer as separate from the observed, which is consistent with the modernist tradition and normative social science. Traditional social science tends to focus on research questions that are consistent with the ideology of the society in which the research is conducted (Becvar & Becvar, 1996). Similarly, the primary unit of study is the individual, while systems and interactional patterns remain mostly untouched in research questions.

However, post-modernism and second-order cybernetics require something different from the researcher. According to Becvar and Becvar (1996), the spirit and underlying philosophy of qualitative research is more consistent with the cybernetics of cybernetics. Qualitative research acknowledges subjectivity and that we can only do research in terms of our representations of the world. In qualitative research, questions of interest dictate the research design, and research is thus not limited to those questions that fit an accepted research protocol. Some forms of qualitative research move the researcher out of the role of the expert into a participant mode, and as a result, qualitative research and therapeutic conversations may be indistinguishable from one another (Becvar & Becvar, 1996). Further, the research may focus on the social domain – for example on relationships and interactions – rather than on the individual, and on understanding the larger context.

Qualitative research is more likely to be a discovery-oriented inquiry than hypothesis-testing study. Data and interpretations are seen as valid only under the specific conditions of a particular project at a particular time and place, as observed by a particular observer, rather than as absolute and objective facts, which would be the case

when working in the traditional research spirit. Qualitative methodology fits very well with the therapeutic approach to understanding the world through socially intense interactions with people who are suffering.

### The Researcher

#### *The Social Researcher*

The construction of one's meaning has two dimensions: the individual lens, which focuses on the personal context of interpretation, and the social lens, which focuses on the social context that creates the individual. It should not be forgotten that at any point in time the individual is the repository of his or her social experience. The identity of the individual is "at once both individual and social" (Ackerman, 1958, p. 7). Ackerman further points out that we need to focus on what happens between the person and the environment, especially on what gets distorted in the social processes. He stresses that we need a unitary approach which combines physiological, psychological and social processes to achieve a meaningful conception of human health. Social constructionism theory, similarly, speaks not of the individual mind but of the meanings generated by people as they collectively generate descriptions and explanations in language. In each case, however, the social researcher must focus on the manner in which conventions of language and other social processes influence the construction of reality.

In social research the interdependence of "observer" and "observed" is an important aspect which takes into account the context of interaction, which is seen as a process of mutual influencing where the emphasis is on what is happening rather than on why it is happening (Becvar & Becvar, 1996). Understanding another human being occurs in an interpersonal setting, and it is therefore essentially an interpersonal phenomenon. Interpersonal interaction involves a flow of emotions and information in both directions, which enhances mutuality and understanding (Starcevic & Piontek, 1997). Our understanding and knowledge are often based on our particular belief system, which the researcher should readily identify and acknowledge. The research

study I discuss in this document follows the social research approach, which holds that the relationship between researcher and researched should be one of mutual respect, and that such a relationship is more likely to elicit sensitive thoughts and feelings in both parties (Berg & Smith, 1985).

With regard to knowledge, social constructionism sees it as part of the coordinated, interdependent activities of individuals (Gergen & Gergen, 1991). Further, it takes the view that the outcome of the researcher's cognitive process will be shaped by his or her biases.

The social researcher has a particular interest in parallel processes, where there is the probability that two or more systems having significant contact with one another will have similar affect, behaviour or cognition. Interpersonal influence is seen as an important component of parallel processes (Alpher, 1991). Steier (1991a) points out that we should be aware of what he calls mirroring, which may be a crucial way of understanding how our "results" become results.

The self-reflective perspective I have taken in this research is understood as imperative in social research. It can help develop both an intellectual and emotional understanding of the dynamics inherent in a human system's struggle to learn about itself, especially when confronting failures, imperfections and weaknesses. Berg and Smith (1985) maintain, further, that it is absurd to act as if biases are not present, because they are an inevitable influence. They point out that a self-scrutiny process is vital despite the difficulties and complexity of a process in which researcher and "researched" are simultaneously influencing each other. According to Edelson (1985), being a skilled observer requires the ability "to acquire the kind of insight into one's own mental life and propensities that will expand one's observing capacities" (p. 79). He suggests that the researcher should be encouraged to become aware of herself as an instrument for making observations and should learn what random or systemic influences arise from herself.

Lowman (1985) makes the point that those attracted to the clinical study of social systems need to address conflicts in the area of counter-dependency and in the

experience and exercise of power. He concludes that these issues, as well as professional isolation and loneliness, are best addressed through personal therapy and peer support.

Clinical research into social systems, says Hackman (1985), creates an experience of the world that is more complex than that created through either/or thinking, by providing the means of understanding that acknowledging the world as subjective means acknowledging the complexity of multiple realities.

### *The Subjective Researcher*

The emergence of the post-positivist paradigm made its impact not just on the theory and practice of social science, but also on research methodology and design.

In the positivist paradigm, research methodology followed strict rules of objective science, in line with the belief that the observer, as a separate entity, can be objective. The traditional quantitative method was commonly associated with the positivist paradigm, while the post-positivist paradigm introduced a qualitative methodology. Moon, Dillon and Sprenkle (1990) observe that the traditional methodology has been criticised as inappropriate for studying family systems since it often ignores the social context, does not gather information from multiple levels and is unable to study recursive interactions. Qualitative methodology, according to Moon, Dillon and Sprenkle (1991), is useful in “discovery-oriented” research. Description and explanation rather than prediction are the characteristics of qualitative methodology, where data are typically presented in the form of narrative and a description of themes.

This research study relies on a naturalistic methodology in its subjective, interactive and qualitative nature. As therapist, I take a subjective, reflective stance in my participation in the project. The research is consonant with a naturalistic position, as reflected by the development of broad questions which continuously shift and change (Ely, 1991).

In qualitative research, the human is regarded as an instrument of the research and a natural setting is vital for understanding a particular phenomenon, which is related to the context of which it is part. Qualitative research is subjective, and should reveal the

way in which the observer is organising her reality or world (Atkinson & Heath, 1987). When undertaking such research, it is imperative to learn to trust oneself as a flexible instrument and to trust the research paradigm as worthy and respectable (Ely, 1991).

The subjective mode in which I have carried out my research is based on three assumptions: (a) different therapists will focus on different aspects of the same story; (b) they will each formulate different questions and discover different answers in relation to the same story; and (c) each will begin the process of understanding from his or her own assumptions (Bernardi & de Leon de Bernardi, 1993).

The frame for the research is congruent with Peshkin's (1985) view that "my subjectivity narrows what I see and shapes what I make of what I see" and assumptions "unlike clothing ... are pre-existing states that cannot be shed and thereby prevented from interacting in some way with the objects I study" (p. 278). According to her, subjectivity can be counterbalanced by developing a creditable intersubjectivity, which is achieved when others agree with the researcher's specific perceptions or interpretations.

Moving into an intersubjective world means that the researcher/therapist and client are both responsible for co-creating this world, as they may be for co-constructing their stuckness in it. The therapist is no longer viewed as an arbiter of the truth; instead the ideal becomes awareness of one's subjectivity and tolerance for "not-knowing" (Darwin, 1999).

While objectivist researchers could ignore the value implications of their research activities, constructivist researchers are forced to acknowledge their influence on the research situation and their role in co-constructing the reality. Simmons (1985) postulates that instead of pretending to objectivity in "scientific" psychology, which worships detached objectivity, we should seek to understand our subjectivity by looking at our biases. This implies taking responsibility for our own process.

The relational therapist utilises self-analysis as a method of becoming aware of her own, previously disavowed subjectivity. Darwin (1999) warns that such a therapist needs to be prepared to use her subjectivity and to take heroic actions that may deviate

from her usual therapeutic stance. She adds that the therapist's "leap of faith" (p. 461) is likely to be followed by a lack of certainty as to the outcome and the possible disapproval of the therapist's peers. In order to constructively deal with subjective interference, taking the self-reflexive stance helps us understand our subjective construction of reality and this "heroic action" should therefore become a priority for future researchers.

### *The Self-Reflexive Researcher*

Second-order cybernetics and the concept of circularity have forced researchers to accept responsibility for their observations, descriptions and explanations. We have embarked on a search for self-defined constructions, which guide us in our understanding of research phenomena. Subjectivity has contributed to a deeper understanding of phenomena and should be acknowledged and included in the research process through self-reflexivity. This can be understood as a "bending back on itself" where the self may shift to a different self as a result of its own "self-pointing" (Steier, 1991a, p. 2).

Research can now be understood as telling ourselves a story about ourselves where inclusion of the researcher makes all research autobiographical (Steier, 1991a). How we define the domain of the problem, how we present ourselves to the subject of our research, and how we receive responses and judge their relevance, are all elements that shape our findings. Our prior assumptions as well as our situational behaviour will therefore influence the research process, while our capacity for self-reflexivity will be closely related to our awareness and acknowledgement of our subjectivity.

Self-reflexivity has its roots in the psychodynamic concept of self-analysis. Originally, self-analysis was related strictly to transference and counter-transference (Barron, 1993) – concepts that refer to the unconscious tendencies of both client and therapist to relate to each other in terms of previous experience (Sachs & Shapiro, 1976). However, post-modern thinking has changed and expanded the concept of self-analysis so that today, says Barron (1993), analysts increasingly appreciate the ongoing necessity

for self-analysis to reveal how our inner worlds actively shape, and are shaped by, the inner worlds of our patients.

In this research, I pursued a process of self-analysis in the belief that it would enable me to become aware of the assumptions emanating from my own psychic reality that shaped my understanding of the therapeutic process. Self-analysis did indeed help me, as a therapist, to examine my theoretical assumptions and other unquestionable truths and to make progress toward a more appropriate use of theory. Further, the blind spots and inhibitions brought to light by self-analysis and conscious reflection led to a greater degree of emotional freedom (Bernardi & de Leon de Bernardi, 1993). The process of self-scrutiny led to a clearer definition of my inner world, which in turn enabled me to explore more fully the realities of my clients.

Self-analysis also enabled me to shift from first-order cybernetics to a second-order perspective where the “expert stance” changed to a more collaborative approach in working with the research group. McLaughlin (1993) describes her own self-reflective process, during which she began to consider “the extent to which my stance of superior knowing invalidated the psychic reality of the patient, and kept us both from understanding how that unique reality view had necessarily come to be” (p. 70). The reasons that prompted my self-scrutiny are paralleled by some of the reasons cited by McLaughlin: “What usually has moved me has been some degree of anxiety, an uneasiness while at work with a patient.... I catch myself in some form of withdrawal” (p. 71). The process in which I was engaged seemed to resonate with McLaughlin’s account of how the shift in her own stuckness was resolved through taking a self-reflexive stance, and of how this led to some surpassingly new understandings of her old difficulties in relation to her family of origin, which she had thought were well settled.

Self-analysis confronts us with the ways in which we cling to our old, familiar ways of seeing and doing, and enhances our freedom to consider other viewpoints. This process in turn has a positive impact on patients and promotes a mutual sense of responsibility for the process. McLaughlin (1993) remarks that through striving to heal others, the analyst is in fact striving to heal herself and that through helping others to

restore their personal past we acknowledge and restore our own and those who helped us shape it.

One of the significant results for me of self-reflexivity was an emerging self, which shifted my position as researcher from that of objective observer to subjective participant.

### *The Participant Researcher*

For this research I adopted a participant-observer methodology, which is the most appropriate when the research problem is related to human interactions viewed from an insider's perspective (Jorgensen, 1989). This methodology provides direct experiential access to the insider's world of meaning and it is desirable for the participant to gain a degree of intimacy with the people and settings of the research. Thus another motive for using this methodology was my involvement in the field of research. As Jorgensen observes, the participant-observer approach is the common choice when the field of research is selected, at least partly, because of the previous or present involvement of the participant.

Jorgensen (1989) goes on to explain, "what is taken to be the problem for research by participant-observation is the result of the flexible, open-ended, ongoing research process of identifying, clarifying, negotiating, refining, and elaborating precisely what will be studied" (p. 32). This kind of research results in highly valid concepts but conventional reliability is not an appropriate measure for such research. However, reliability in participant-observation research is indeed interrelated with validity, which may be checked by multiple evidence given by other researchers.

Jorgensen (1989) says that this process involves flashes of insights about how things fit together, while at other times insight comes through less dramatic hunches, or through simple hard work, and this was certainly confirmed by my own experience. Jorgensen goes on to advise that, while it is important to consult the existing literature, one should not be constrained by what others have or have not done, but should use one's own creativity. He also points out that the uniqueness of the research may not lend

itself to a specific outline or form of reporting and that an appropriate form may need to be developed to allow the uniqueness to unfold.

Participant-researchers need to recognise their “emotioning” and to remain self-reflexive as to how they participate in the research (Steier, 1991b, p. 179).

### *The Emotional Researcher*

The participant position I adopted in this research inevitably generated a highly emotional experience, which held the key for unfolding a personal and family narrative. The intellectual struggle, too, generated an emotional struggle which then led to feelings of anxiety. As Berg (1985) points out, anxiety is most likely to surface when researchers confront personal weaknesses or current struggles in their identity. The struggle and anxiety are part of control issues where the “researched” is complex and out of the researcher’s control.

Berg (1985) also maintains that we need to pay more attention to the effects of the research relationship on the researcher. Instead of denying our feelings, we should acknowledge them as an inevitable part of clinical research – especially when we use ourselves as the research instrument. He observes that current training provides no examination of difficult emotions, which are part of clinical research, and he urges researchers to report on emotional dynamics in research relationships and to publish this material.

Discussing how studying emotionally hot topics influence researchers, Sutton and Schurman (1985) describe a variety of emotional responses ranging from anger to depression, guilt and distrust. These emotions may interfere with the researcher’s ability to relate to the “researched” if he or she copes by becoming detached and procrastinating. Nonetheless, these authors believe that researching topics that are likely to create deep emotional responses from both researched and researcher is potentially advantageous. Instead of trying to eliminate our “emotioning” and prevent it from entering into our research, says Steier (1991b, p. 179), we should rather seek to understand how it does enter. Maintaining a self-reflexive stance allows the researcher to

investigate her “emotioning”, which can provide a deeper understanding of the research process.

Friedman (1991) uses Glazer’s concept of “compassionate analysis”, where the researcher’s emotions become intertwined with those studied, and claims that such a process can result in rare analytical insights. She notes that while researchers who engage in such an analysis are likely to experience a variety of positive emotions, such as compassion and warmth, they are just as likely to grapple with feelings of self-doubt and uncertainty, sadness, anxiety, fear of disclosure and loneliness. Acknowledging and working through our emotions rather than denying them will, she believes, create space for using our emotions to our advantage. She concludes that in order to understand a client’s experience, the therapist must attempt to recognise personal prejudices, assumptions, feelings and thoughts that may distort his or her perception. Confronting oneself and one’s biases is the most difficult, painful and thought-provoking process in clinical research. Yet, as Friedman points out, perhaps all research is, in fact, based on “me-search”. She adds that in that process, the willingness and ability to tolerate strong emotions may become an important source of strength.

In addition to the difficulties already noted, studying oneself may also be excruciatingly difficult because, as both researcher and researchee (often simultaneously), one has to develop double vision. Moreover, our version of ourselves may be self-deceptive (Polonoff, 1987), and this may have to do with facing the pain of seeing what we would wish not to see (Friedman, 1991). Living with the real self and not living a lie is not always an easy task, as we tend to be selective in our memory and self-deceptive in our narratives. In the process of studying oneself, several characteristics are crucial: flexibility, using humour, accepting ambiguity, empathy and accepting one’s emotions (Friedman, 1991).

Essentially, qualitative research requires an ever-evolving process of exploring, analysing, and changing. Anzul (1991) writes that the effect of the research on the researcher, and its transformation of the researcher, is sometimes unanticipated and may create a sensation of “working within a hall of mirrors” (p. 196). According to her, change and transformation are inevitable when the emotional, self-reflective mode is

introduced. Research then provides learning that is self-discovered and creates the space for self-growth.

### Research Aim

People who are oriented toward research are commonly not much interested in therapy and, likewise, therapists are often reluctant to perform research. Therapists often refrain from getting involved in research because traditional quantitative methods may not readily fit with questions emerging from clinical work. Qualitative research is, however, a more appropriate method when used in studies that are immediately relevant to ongoing clinical work (Maione, 1997).

Originally, when I began therapeutic work with children suffering from thalassemia major, and with their families, my focus was on problems relating to compliance with the prescribed treatment (Sargent & Liebman, 1985). My curiosity about the disease and the compliance problem became a starting point for my research. My initial perspective was positivist: I viewed the therapist as an objective outsider observing the observed. The first-order paradigm was, accordingly, my guiding principle and my research aim was to simply look at the factors related to the compliance issue.

A first-order stance meant focusing on the group and their illness narratives without including my role as therapist. At that stage, my aim was related to the compliance problem and to therapeutic interventions that would be instrumental in improving compliance. The idea was that psycho-education would bring about the desired improvement. This rigid view seemed to narrow the possibilities for improving compliance and consequently led to a lack of progress.

Traditional training, it seemed, was insufficient to prepare me to cope with the unique challenges I faced when I began my work with terminally ill children and their families. My lack of progress created a need for self-reflection on certain personal and professional issues, which made me aware of how I had participated in the therapeutic process. This emerging self provoked a shift to a second-order perspective. In terms of

subjective epistemology, I have now “adopted the stance that I was part of what I was researching, just as I am a significant part of the therapy process” (Maione, 1997, p. 3).

This second-order position meant that my focus as therapist expanded from initially following the group process and working with the issue of compliance to including my own process. The research aim consequently expanded to understanding how working with serious illness was affecting my professional and personal selves. Tolerance for loss and uncertainty, issues of family of origin, personal issues, isolation from colleagues and collaboration issues (McDaniel & Campbell, 1986; McDaniel, Hepworth & William, 1992; McDaniel, Campbell & Seaburn, 1995; Rolland, 1994) were just some of the issues I faced in this self-reflexive process.

I have used a self-reflective narrative to explore the shift I made from the positivist paradigm and an expert position to the post-positivism paradigm and becoming a participant in the therapeutic process. I expand on the idea of the therapist-participant by investigating the effects of my participation. This exploration has required the inclusion of autobiographical elements and self-reflections on changes that occurred during the therapeutic process, in my construction of myself in relation to my position in my family of origin, my marriage and my professional capacity. This process followed the route of clinical qualitative research, which aims to understand more about the nature of the therapeutic process. Such an aim is best accomplished by including the perspectives of both the researcher-clinician and the clients (Maione, 1997). The personal growth that flowed from this self-analysis enhanced my ability to constructively integrate my personal and professional selves.

My discussion of the profound impact of a self-reflexive stance on my professional and personal growth aims to prove the importance of the self-reflective process. As Counselman (1997) has noted, mutuality and participation when working with the terminally ill may have a profound influence on a therapist’s life. In line with this, I believe that a self-reflexive position is crucial to prevent the therapist’s dysfunctional patterns from having a negative effect on the therapeutic process. A self-reflexive stance also contributes to the therapist’s personal and professional growth, which increases professional competence. I therefore propose that personal therapy and

work on the self and the family of origin should become an everyday reality in the professional training, supervision and continuing education of clinical psychologists.

If what we live is inseparable from what we tell (Bruner, 1987), then the therapist becomes a narrative facilitator of the patient's narrative (Shapiro, 1993). When the therapist's narrative expands, this creates a parallel space for the patient's narrative to expand; and when the therapist reconstructs her view it allows her client to do so as well.

My shift from the role of objective outsider to that of participant provoked inclusion of myself. A further aim is to look at a parallel process which occurred in the group where the focus in their stories moved from talking about the family's relations with the medical system (Ballard-Reich, 1990; Bloch, 1991; Holden, Zimmerman & Fortenberry, 1991) to more personal stories. As already noted, the therapist's awareness of "process mirroring" is crucial in providing the context for understanding how her "results" become results (Steier, 1991a). Communication patterns between family members (McDaniel et al., 1992; Penn, 1983), the child's body image and self-esteem (Georganda, 1990), parental blame and guilt (McDaniel et al., 1992), spiritual and religious difficulties (Frank, 1991) and dealing with uncertainty (McDaniel et al. 1992) were some of the personal difficulties that surfaced.

Explorations of the patients' personal stories seemed to make room for the development of alternative stories that promoted healing (Shapiro, 1993). The expansion of the self in their stories brought a surprise in the medical results: improved compliance. This process reaffirmed my belief that it is often when we try to force a change that we land up with stagnation, whereas when we let go of being instrumental, the change may happen when we least expect it. A final aim, then, is to link some of the complex interchanges that occurred in our therapeutic process with the post-modern, intersubjective stance where therapy is viewed as a space for mutual perturbation and brings about a shared reconstruction with both therapist's and clients' stories changed in the process (Viney, 1990).

## Research Design

Guy, Edgeley, Arafat and Allen (1987) define research design as “the plan of procedures for data collection and analysis that are undertaken to evaluate a particular theoretical perspective” (p. 92). The research I have carried out is based on a naturalistic frame. According to Skovholt and Ronnestad (1992) this means that:

1. There is no manipulation of the research setting.
2. The design is inductive and flexible.
3. The research uses qualitative data.
4. The inquiry is characterised by personal contact and depends on the insight of the therapist-researcher.
5. The systems researched are dynamic systems.
6. There is attention to the process and change.

Lincoln and Guba (1985, pp. 39-43) note the following further characteristics of naturalistic inquiry:

1. Natural setting – which suggests that reality cannot be understood in isolation from the context and that phenomena must be studied in their setting.
2. Human instrument – the researcher uses herself as the primary data-gathering instrument.
3. Utilisation of tacit knowledge – we need to include our intuitive (felt) knowledge in addition to knowledge expressed in language form, as multiple realities can only be appreciated in that way.
4. Qualitative method – more adaptable in dealing with multiple realities.
5. Purposive sampling – because random sampling is likely to suppress more deviant cases while purposive sampling increases the scope or range of data exposed.
6. Inductive data analysis – as a process where data are not defined in advance but we make sense of field data in a process where the researcher does not work with a priori variables.
7. Grounded theory – the theory is likely to emerge from (be grounded in) the data because no a priori theory could envisage the multiple realities that are likely to be uncovered.
8. Emergent design – in naturalistic research we need to allow research design to emerge (flow, unfold) rather than construct it a priori.
9. Negotiated outcomes – meanings and interpretations are negotiated with the human sources from which data have been drawn.
10. Reflexive reporting – reporting needs to be adaptable to demonstrate the researcher’s interaction and biases.

11. Idiographic interpretations – because different interpretations are likely to be meaningful for different realities; generalised or nomothetical interpretations are not suitable for naturalistic inquiry.

12. Tentative application – because broad application of the findings is more likely when realities are different and multiple.

13. Focus-determined boundaries – the boundaries of the research are based on the emergent focus because they cannot be satisfactorily set without previous intimate knowledge of the context.

14. Conventional trustworthiness criteria are non-applicable – it would be inconsistent with the naturalistic assumption of subjective and multiple realities; conventional research implies a single, objective reality.

Chubb (1990) maintains that process and development are invariably part of naturalistic research. Researching social systems means researching the process. In that process the therapist has influence but no power. By interacting the therapist changes the interactions in the system, but through interacting the therapist may also change herself. In naturalistic research, say Lincoln and Guba (1985), observation not only disturbs and shapes but is also shaped by what is observed. Thus researcher and researched together create the data of the research through their mutual influencing of one another. This “mutual shaping” (Lincoln & Guba, p. 100) results in multiple constructions, which are greatly influenced by the values of both the researcher and the researched. These writers further assert that in naturalistic research, inquiry is value-bound by:

1. the values of the researcher
2. the values of the context in which the research is carried out. (p. 174)

My values as a researcher had an impact on:

1. the selection of a specific problem to research – in this case the thalassemia major group
2. my choice of the naturalistic and qualitative research method
3. the meanings and stories that I chose as representative of the process. (p. 174)

In respect of my research findings, I do not claim they hold true across time or in alternative conditions (Miller, Nelson & Moore, 1998). However, I do believe that some of the stories that emerged from the thalassemia families may be meaningful to others who are struggling with terminal illness. Further, my story, reflected through the theoretical frame of first and second-order cybernetics, describes my reality in relation to

the process of “mutual shaping” (Lincoln & Guba, 1985, p. 100). My story of “mutual shaping” may also not hold true across time or universally: but I am prepared to predict that when researching in highly charged emotional contexts (such as terminal illness), the researcher’s reality will undergo transformation. It is therefore reasonable to predict that a highly charged, emotional research process will influence the researcher’s reality although it is unreasonable to attempt to predict the direction or extent of such a shift for each individual researcher.

This research differs from conventional research in that at the outset the researcher “does not know what he or she doesn’t know” (Lincoln & Guba, 1985, p. 209) and that an open-ended approach is therefore required. I selected an “emergent design”, taking into consideration the following characteristics of emergent design that are applicable to this research (Lincoln & Guba, 1985):

1. The focus in the group changed in two directions: from compliance and the medical context to more personal stories; and from an exclusive focus on the group to a more expanded focus that included my personal and professional selves.
2. The theoretical frame was not chosen a priori but through the process, from which second-order cybernetics emerged as the most applicable theoretical frame.
3. The research sample of thalassemia patients is not representative but purposeful, in order to increase the range of information.
4. The “instrument” of the research is the therapist – my professional and my personal selves, which underwent a transformation and became more integrated, refined and knowledgeable in the process.
5. Data analysis is open-ended and inductive without any a priori hypotheses.
6. The timing of the process could not be predicted.
7. The end product could not be predicted except that it was likely that “understanding will increase”. (pp. 224-225)

The emergent design proposed by Lincoln and Guba (1985) is well suited to this 6-year longitudinal study where I follow the shifts emerging throughout the process and the impact they had on the researched (patients and their families), and the researcher (the therapist). When I began my therapeutic work with thalassemia families, my focus was, as previously mentioned, on compliance. However, over time the process changed and gained in complexity, so that the focus shifted. This development was not predictable at the beginning of the research, and the ideas and meanings that emerged

from an evolving design arose from an interactive process that could also not be predicted in advance. Subsequently, the interaction process had a major impact on my reality and I have therefore included my process as part of the multiple realities created by the emergent design. I explored my process using a self-reflective style that is increasingly found in scholarly, qualitative studies (Searight & Young, 1994) and is well suited to looking at one's personal biases.

### Participants and Process

In Gauteng, thalassemia major is treated in only two hospitals – Johannesburg General and Coronation. Johannesburg General Hospital treats patients of Greek origin, while Coronation Hospital treats those of Indian origin. Twenty-six thalassemia major patients are treated at Coronation. Patients are split into four groups, each group receiving blood transfusion once a month. Some of them have to travel for a few hours to get to the hospital in order to receive a blood transfusion; and some of the families have more than one thalassemia major child.

Many factors in this research were unpredictable. For instance, I never knew in advance whether we were going to have a session and how many mothers or children would participate. Each session was different. The number of participants depended on numerous variables, such as a child's medical condition, the number of nursing staff, whether the parents had transport, and other unpredictable factors. At times I also saw thalassemia patients who were not part of the initial group, mostly when they were experiencing a medical crisis.

The space in which sessions were held was also typical of emergent design conditions in that I usually did not know in advance where I would find an office or a room in which to see the group. A major difficulty was that mothers declined to join the sessions if they were held too far from the ward where the children were transfused. There was always a lack of nursing staff and mothers worried that if they were all at the other side of the hospital and something went wrong with their child, there would be no one to help. My office was in another building, so from the start that was not acceptable.

Another difficulty was lack of space. Anyone who has ever worked at Coronation Hospital will know how everyone fought with everyone for the use of a room. I had no option but to accept minimal conditions in respect of space, and when no room was available I saw the mother group in the children's ward where their children were transfused. It was difficult to talk while what felt like a million kids were screaming, crying, playing or asking us questions. Another concern with such a space was that the sound quality of the audio-tapes I recorded there was very poor.

The type of session was another emergent factor. Once again, when and as the need arose, the decision would be made on the spot about the most appropriate way to conduct the session. I conducted individual sessions, couples sessions and family sessions when requested to do so by a mother or a child or, on occasion, by the medical staff. The most common reason, from the medical point of view, for requesting a particular type of session was an increase in ferritin level, or a heart failure, or an HIV issue.

I started with group sessions for the mothers in 1994. One group consisted of six mothers with a second group of two. I usually saw the mother group and then had play sessions with their children on the same day. To start with, one playgroup consisted of seven children aged between three and fourteen while the other group had three girls aged between five and seven.

Consistency was almost impossible in the chaotic conditions at the hospital. Through the 6 years of this study, there were numerous occasions when sessions were cancelled. Sometimes we could not find a room, sometimes there was a shortage of nursing staff which meant that the mothers had to check on the blood, sometimes I had urgent referrals or meetings, sometimes children had a reaction to the blood and did not feel well. The list of unpredictable factors is endless.

At the end of 1994 a 16-year-old thalassemic was urgently referred to me after surviving heart failure. I conducted individual sessions with him on a fortnightly basis, and daily when he was hospitalised at critical times, until he died in May 1997. During 1994 and 1995 I saw the two oldest thalasseemics, aged 19 and 23, for occasional group

and individual sessions. These two had no regular input from me: at specific crises with compliance I was asked by the doctors to “talk some sense into them”.

At the beginning of the process in 1994 I had no intention of carrying out research on thalassemia major, and I therefore took no audio-tapes. For research purposes I subsequently used my process notes for analysis of the first year of therapy. From 1995 to the middle of 2000 I recorded most of the sessions with mothers. I did not record play sessions with the children but I conducted several group and individual sessions with the children, which I did record. I have included some of the drawings made during play sessions in the research, as well as a poem entitled “Yesterday, today and tomorrow”, which I was given in 1996 by one of the thalasseemics whom I saw infrequently.

There were occasions when I felt that a request to make a recording would be insensitive, such as when I conducted sessions at V.H.’s deathbed at the hospital. A few sessions that were conducted in the children’s ward were not recorded because the level of noise would not have permitted adequate sound quality. The tapes and process notes were analysed in relation to emerging themes and stages in the six-year process.

The process in which the researcher categorises units of information is well described by Marshall (1981): “the units are really fairly obvious – you get chunks of meaning which come out of the data itself. If you read a side of transcript, there is something which comes out to you... These are chunks of meaning, and you don’t have to look at individual sentences, or debate what the level of analysis is... I let the categories build up all the time as I put things together that go together” (p. 397). Researching in a clinical setting relates to researching stories expressed through language. A narrative approach is especially useful in understanding such complex phenomena as exist in a medical setting (Searight & Young, 1994). The construction of meaning rests in stories, and storytelling seems to be the most universal way of describing human interactions. The researcher’s position resonates with a narrative understanding of his or her subjectivity as a significant element in selecting and developing themes for research (Stern et. al., 1999). Sometimes the stories can be expressed by a medium other than language, such as the photographs I have used in this

research as I believe that photography is a visual medium for story telling. I have included photographs of the Westbury area as the larger geographical context of the research and of Coronation Hospital itself. For the specific medical and illness context I have used photographs of transfusion day, the desferil pump, and scarring on children's stomachs and thighs from the pump needle. There are also pictures of the children and mothers at one of the Christmas parties and in the ward. An especially dear photograph to me is the one taken of V.H. and myself in the ward just a few months before his death from heart failure. In the autobiographical chapter I have included personal photographs of myself in different life stages, and family and wedding photographs.

### Research Trustworthiness

Atkinson, Heath and Chenail (1991) hold that research legitimacy can be established through a communal judgement process where responsibility for the trustworthiness of research findings can be shared. They point out that qualitative researchers have devoted much time to developing methods that allow them to prove that "you can trust my findings" in a similar sense to the trustworthiness claimed by conventional researchers, but any method or angle of observation has its own limitations and bias. They note the example of the family therapy pioneers whose methods were rarely well documented but whose insights had a great impact on the field of family therapy. In these instances, legitimisation occurred primarily through clinicians "testing" out the insights and methods on their own. Over the course of time, this resulted in broader support for some methods and theories than others (Atkinson et. al., 1991). This suggests that an imaginative researcher who follows no discernible systematic procedure may come to insights at least as great as those of a task-oriented researcher. Some authors believe that responsibility for trustworthiness should not lie solely with the research community, although individual researchers have an ethical responsibility to assure that their findings are as accurate and trustworthy as possible (Moon et al., 1991).

Another important step in establishing credibility is to look at the visibility of the research data. Visibility refers to the extent of the access other researchers have to the actual data from the study (Maione, 1997). Qualitative research works with description

and explanations rather than predictions, and data are typically presented in the form of narratives and descriptions of themes. To enable readers to judge the accuracy of my descriptions and explanations I have provided a certain amount of raw data from the session tapes and process notes, presented according to themes (Searight & Young, 1994, p. 125), and children's drawings.

Prolonged engagement is another factor that increases the probability that credible findings will be produced (Lincoln & Guba, 1985). I invested 6 years into my research with thalassemia major families. Such prolonged engagement allowed sufficient time to build trust and to learn about the Indian culture and religions, which were important factors in fully understanding and appreciating the context. In addition, I underwent a developmental process that emerged from this prolonged engagement, and this created unpredictable shifts in my understanding and interpretation of the process. One of the challenges was to become flexible enough to let go of my a priori assumptions, like the assumption that basic psycho-education on thalassemia and compliance would lead to an improvement in compliance. However, although it is difficult to give up this kind of assumption, Lincoln and Guba (1985) observe that if the researcher's constructions remain the same throughout the research process and "if the investigator produces the field notes and makes interpretations that are continuously predictable from the original formulation, then that investigator has either not spent enough time on site or has persisted against all logic in his or her ethnocentric posture" (p. 302).

Since I have taken a post-modern approach in this research, validity and reliability, which are commonly used in quantitative studies and are based on positivist assumptions, are considered inappropriate. Krippendorff (1991) points out that reliability has traditionally been associated with measuring instruments, where it expresses the degree to which a measuring instrument is independent of variations in different circumstances of its application. He discusses three ways of measuring reliability: accuracy, stability, and reproducibility. Accuracy is not applicable for qualitative research as it presumes knowledge of what is to be described before it is described. Stability focuses on the consistency of the measuring instrument's performance, which

once again is not applicable in research of this kind, dealing as it does with human subjects in the emotional context of terminal illness. Reproducibility relates to what social scientists call inter-observer reliability, which also has limited applicability in naturalistic research.

Reliability needs no knowledge of what it is that is being observed; it rests on the assurance that different observers see and describe the same units. It does not measure consensus as it requires independent observations and understands reality as objectively existing outside of the observer. It is usually tested by replication. This research, on the other hand, is based on constructivist theory, which sees reality as a subjective construction. This means that we accept that each client or researcher may experience a different reality when exposed to the same perturbations, and may experience the same event differently in a different time dimension. The constructivist perspective moves away from presuming that there is an objective reality or that one observation is more or less objective than another. It is therefore inappropriate to talk about conventional stability and consistency since we are assuming the existence of subjective and multiple realities (Golann, 1987; Simon et al. 1985).

Validity refers to the degree that research data correspond to the real nature of the world. This conception assumes subject/object dualism in inquiry and the existence of an objective world outside the observer, and it leads to a reductionistic view of human behaviour. Shovholt and Ronnestad (1992) emphasise that validity in qualitative research involves uncertainty and probability and can only be addressed through dialogue.

Once it is accepted that reliability and validity are not useful in establishing the credibility of qualitative research, the researcher has to build ways to enable the reader to assess how credible the study and the findings are. One important concern that relates to credibility is researcher bias (Maione, 1997). The qualitative researcher is more likely to see bias as something he or she will not be able to avoid, but perhaps, as Greene (1994) explains, it is "precisely the individual qualities of the human enquirer that are valued as indispensable to meaning construction" (p. 539). With this in mind, I have tried to enhance the credibility of this study by presenting my own characteristics and

belief system (Moon et al., 1991). In order to make my biases more visible, I have also included my autobiographical story, which has created the historical, social and personal context for understanding my personality, therapeutic style, beliefs and assumptions in respect of my professional and personal selves.

I have used a genogram format to graphically display personal and family information, since the genogram provides “a quick gestalt of complex family patterns and a rich source of hypotheses about how clinical problems may be connected to the family context” (McGoldrick & Gerson, 1985, p. 1). It is a subjective interpretive tool, which can help the clinician to see the larger picture. Genograms allow the clinician to map clearly the family structure and to note and update the family picture as it emerges. I have presented two different genograms. The 1994 genogram reflects the family “picture” at the beginning of the process. The second genogram depicts the situation 6 years later, in 2000, and gives the reader a graphic presentation of the personal and professional shifts I went through as a result of my work with the thalassemia groups, which had a profound influence on my family picture.

To further enhance credibility, I tested my findings by interviewing the mother and children thalassemia groups about their experience and interpretation of the six-year process (Lincoln & Guba, 1985). I asked each group to comment on the process they experienced and to share their ideas on the process that others went through. They discussed their understanding of why ferritin was at life-threatening levels during 1992 and 1993 before they began therapy. They also explained their interpretation of the significant drop in ferritin levels in the last few years. Finally, they reflected on how they had experienced me during the six-year process.

Looking back at the process that has run its course over the last 6 years, I feel the following words reflect its essence for all of us:

“You are not the person you were when you began” (Lofland & Lofland 1984, pp. 119-120).

## CHAPTER 4

### THE BEGINNING

#### The Medical Context: Coronation Hospital

Coronation Hospital is an historically disadvantaged hospital treating mainly coloured, Indian and black patients. In 1994 the Gauteng Health Department decided to close the hospital but the coloured community violently opposed the closure, and following clashes that left several people dead and injured, the Department decided to keep Coronation open, but change it from a general hospital to a specialised service provider for mothers and children. This meant that services had to be split between the Coronation and J.G. Strydom hospitals (the latter now known as Helen Joseph Hospital). Thus in 1995 Coronation Hospital became a specialised mother and child hospital with paediatric, gynaecology and obstetrics departments. The thalassaemia haematology unit remained unchanged at Coronation, and continued treating the Indian population.



*Figure 4.1* Coronation Hospital

That Coronation was a disadvantaged hospital was clear to me the moment I entered the premises and saw how poorly maintained it was. Historically J.G. Strydom, which is just one kilometre from Coronation, mainly treated the white population, and maintenance there seemed to enjoy proper financial support from the

government health structures. Although the number of hospital beds at the two hospitals was nearly the same, the number of staff allocated to some departments at J.G. Strydom was double the allocation at Coronation. This historical difference may explain why J.G. Strydom had an established psychology department with two full-time psychologists and three interns, while there was no psychologist at all at Coronation.



*Figure 4.2* Westbury is the township area in which Coronation Hospital is located.

Lack of resources and staff was the norm at Coronation, even though it treated the populations of areas such as Westbury, Coronationville and Eldorado Park, which are notorious for violence and gang-related crime and are afflicted with major socioeconomic problems such as unemployment and lack of living facilities. Families seen at Coronation typically consist of a single mother with several children from different fathers, none paying maintenance. The mother is usually unemployed, and has 4 or 5 years of primary school education. She drinks heavily and lives with a boyfriend who abuses her physically. She shares her household with her mother and several other cousins or siblings who are also single mothers with a few children. Five to seven people sleep in one small room and each bed is shared by two children. At least a few of her children have learning problems and at least one has been sexually abused by either her biological father or one of the male cousins. By adulthood all her children will have been exposed to violent, destructive family

communications on a regular basis. The referral is usually through a schoolteacher for poor progress, and then the rest of the story unfolds. The question then is: what are the priorities and which problem should be addressed first? Usually this kind of case requires the involvement of different hospital departments and outside agencies, such as Child Welfare, the Police, Social Services or Alcoholics Anonymous. The “help” we should offer becomes a very complex issue when so many different systems are involved, and the lack of communication between these systems results in disappointments or frustration for both clients and professionals.

I can see some parallels between the chaotic communities served by Coronation and the hospital system itself in characteristics such as lack of resources, motivation, and communication. Hospital salaries are very poor, posts are often frozen yet the workload stays the same or is increased by the health department, leaving the staff feeling abused and angry. Ultimately, this results in strikes that paralyse the hospital.

Speaking about chronic hospital culture, Ludwig (1971) describes how the hospital system on the one hand offers protection for its personnel (job security, medical and retirement benefits, sick leave) but on the other hand produces a civil service mentality, which is not at all conducive to innovation and active involvement with one’s work. As a result, “mediocrity rather than the pursuit of excellence comes to be the rule rather than the exception” (Ludwig, 1971, p. 71). The job is seen as work rather than as a source of enjoyment and self-fulfilment. Ludwig argues that hospital staff display values that emphasise group loyalty, antagonism to authority, doing the minimum amount of work and avoidance of responsibility, and that these are not so dissimilar from the values often displayed by chronic patients treated in the hospital. The daily routine of running a hospital ward is apt to get boring, and when staff no longer feel stimulated by their jobs they become apathetic and querulous, or divert their attention to personal concerns. Ludwig concludes that because hospital staff constantly deal with the feelings of frustration, anger and discouragement that arise from working in a chronic system, it is essential to provide opportunities for them to ventilate their feelings and receive emotional support.

At Coronation we struggled with a lack of funds for the most basic things; anything and everything was late; and the hospital was invaded by cockroaches that

even the most advanced technology failed to exterminate. Almost every year that I spent at Coronation, the health authorities made attempts either to close it or make changes. We were usually asked by the superintendent to respond to these crises by writing letters to head office, and in most cases the request was made at the last moment. In such a chaotic system it was not surprising that the work was constantly crisis rather than routine-oriented. This was especially so in the psychology department because of the type of referrals and their urgency (rape or suicide attempts were very common, usually several in a week), and the lack of staff. I covered all the referrals from ten different paediatric clinics and five wards by myself for 4 years. I was also required to participate in hospital meetings, of which I was usually informed on the day.

When I look back, it is clear to me that the greatest stress was often related to the chaos in the system, and that in such circumstances it was difficult for most staff to maintain their motivation and a high quality of performance. The chaos and lack of motivation certainly affected patients and the quality of the care they received, which was often reflected in the comments the thalassaemia group made about the hospital and medical staff. Patients had certain expectations of the hospital staff that, when voiced, seemed to provoke negative reactions from the staff. Ludwig (1971), in discussing patients' behaviour, points out that patients' nuisance behaviour will evoke anger and irritation from the staff.

In my first year at Coronation I spent most of my time getting to know everyone and promoting the psychological service I was establishing. My referrals came from the paediatric clinics and wards, as my post was allocated from paediatric posts. In 1994 the paediatric consultant asked for my help in dealing with a group of children suffering from a blood disorder called thalassaemia major (or Cooley's anaemia).

The Coronation Hospital Haematology Unit at that time treated a group of 26 children and adolescents with thalassaemia major. The paediatrician explained that the problem that was being experienced had to do partly with medical non-compliance and partly with the great difficulties encountered by the medical and nursing staff in dealing with the parents. According to the paediatrician, the parents were demanding and made openly critical remarks on the quality of the medical care and the

conditions in the ward, which resulted in poor relationships between the medical staff and the thalassemia group.

The paediatrician pointed out that a few older patients might also benefit from supportive therapy.

One of the three older patients was in a particularly critical condition because his level of iron was extremely high. While describing the illness and difficulties, the paediatrician used medical terms that were unfamiliar to me. At the time I had no experience in working with serious childhood illnesses. In fact, I had never even heard of an illness called thalassemia major. I had no specific interest in terminal illness and I was already beginning to struggle with the overwhelming number of referrals, but I was unable to say “no”.

Seaburn, Gawinski, Harp, McDaniel, Waxman & Shields (1993) discuss the experience of therapists and doctors working in collaboration with one another. The difficulties they run into are associated with differences in models (biological-psychosocial), ways of thinking, differences between psychological and medical language, differences in relationships and time setting between therapist-patient and doctor-patient. Other issues that may prove contentious have to do with the therapist over-emphasising the role of the mind over the body (McDaniel et al., 1992), whereas the medical staff are likely to give more attention to the body. Collaboration requires bridging these differences in training, conceptual models and value systems (McDaniel & Campbell, 1986).

The paediatrician briefly explained to me that treatment compliance is the parents' responsibility as they inject their children with a medication called desferil every evening, which relieves the body from iron overload. I decided that a “quick fix” might lie in educating the parents, focusing on compliance. As regards the children, I thought that transfusion time might be very boring as they spend the whole day lying in bed, and that creating some fun while they were at the hospital might improve their mood. I decided to introduce playtimes, using games, stories, and drawings.

There were four groups of parents attending the haematology clinic every week, all consisting of mothers, because in Indian culture it is the woman who cares for the children. Litman (1974) maintains that the wife-mother “remains the central

agent of cure and care within the family complex” (p. 505), Of these four groups, two responded with interest while the remaining two reasoned that because they travelled a considerable distance to the hospital, they were always late and would have no time for extra things such as group sessions. After consulting the paediatrician, the decision was made to start group work with the mothers and to have playgroups with the children.

As explained in the previous chapter, the frequency and timing of our sessions was unpredictable and depended on different factors each time: the time of transfusion, a child’s reaction to blood, or lack of staff which meant that parents had to play the role of nurse for their child. After several unsuccessful attempts to meet at agreed, predetermined times I learnt to just pop over a few times during the day to the ward where the children were transfused and check whether or not we could meet. Occasionally it happened that when they could make it I had an urgent case, or supervision with students, or a management meeting. These factors, plus the recurrent problem of finding an available room, were very frustrating. Walking to the other side of the hospital with children on blood transfusion machines was an impossible mission. However, I had very little control over any of these problems.

My initial idea for the group sessions with parents was that if we explored the issues in the “right way”, this would result in an improvement in their compliance. This assumption was supported by the paediatrician, who suggested that educating the parents about compliance was the most important thing to “work on”.

## Professional Self

### *The Expert Stage – First-order Stance*

During 1994 I had six 30 to 45 minute sessions with each of the two groups of mothers. I learnt some basic facts about thalassemia major and compliance, and then I organised lectures for the mothers. The obvious assumption underlying this plan was that parents’ increased knowledge would improve their compliance with desferil treatment. Taylor and Aspinwall (1990) point out that patient-education programmes can increase knowledge about the disease, reduce anxiety and increase patients’ feelings of purpose and meaning in life. Gerber (1986) concludes that

knowledge of medical treatment increases compliance rates, although these tend to decrease the longer the regimen has to be followed.

Before I began the group work I searched for literature on thalassemia major and compliance. My initial reading was very narrow, and focused on basic medical information. The knowledge I acquired was, from a systemic point of view, first-order knowledge in that it was instrumental in maintaining the power differential between the therapist and the group.

### *Thalassemia Major and Compliance*

Thalassemia major, or Cooley's anaemia, is a severe, inherited anaemia that drastically affects the life of patients and their families (Gill & Kelleher, 1980). Babies suffering from this blood disease are born with an absence of the synthesis of one or more of the globin chains of haemoglobin made by the body (Georganda, 1988). Thalassemia can occur only if both parents are carriers of the thalassemia trait. Onset of the disease usually occurs by 6 months of age, with irritability, failure to thrive, diarrhoea and abdominal enlargement as common findings (Gill & Kelleher, 1980). A regular transfusion programme, usually every 2 to 3 weeks, maintains the haemoglobin at close to a normal level. The amount of blood necessary for the transfusion of red cells increases as the child grows.

Thalassemia major is common among populations around the Mediterranean Sea, especially in southern Italy, Greece, Cyprus, Turkey and the Middle East. It is also found in parts of the subcontinent of India, Pakistan, Indonesia and China. Among the people who emigrated from these countries to South Africa there were many carriers of the disease, who introduced the illness to this country. The annual treatment costs about R60 000 to R70 000 per patient, and at the moment it is completely state subsidised.

In rural areas and among the poor communities of India, families could not afford treatment, and as a result, afflicted children developed physical deformities and usually died by early puberty. When thalassemia major is untreated or inappropriately treated (low transfusion regimen), the child develops a large spleen and a characteristic appearance, with prominent cheekbones, slanting eyes,

overgrowth of the upper jaw and jumbled upper teeth (Gill & Kelleher, 1980). In the rural communities parents were ashamed of these physical deformities and they isolated their ill children and literally hid them away from other people. The prejudice extended even to schools, where teachers refused to have thalassemia patients in their classrooms (Georganda, 1988).

The clinical presentation of thalassemia major is as follows (Georganda, 1988):

1. failure to thrive and growth retardation
2. enlargement of the liver and spleen
3. characteristically abnormal haematological findings in blood analysis
4. skeleton deformities
5. accumulation of iron in the body that later affects the heart, pancreas, liver and endocrine system
6. delayed sexual development and inadequate sexual functioning (infertility).

The major complication of frequent blood transfusions is the development of significant iron overload and organ damage, particularly to the heart (Gill & Kelleher, 1980). Every 400 ml of blood transfused contains about 200 mg of iron, which gets stored in the liver, the heart and the endocrine glands (Vullo et al., 1997). The human body has no natural way of removing the iron overload, and this overload in the endocrine glands causes diabetes mellitus, calcium deficiency, poor thyroid function and impairment of sexual functioning. Although blood transfusion keeps the child alive longer, he or she eventually dies from the complications caused by the deposits of excess iron in the heart muscle as a result of the blood transfusions (Georganda, 1988). Cardiac failure, arrhythmias and heart block are the leading causes of death in transfused thalassemic children.

In order to remove the iron overload iron chelation therapy is required. For this a slow, subcutaneous infusion of a desferrioxamine called desferil is necessary, at least six times a week, for eight to ten hours at a time, preferably overnight and with the aid of a special pump (Georganda, 1988). One of the ways of checking the iron overload is to measure the level of the child's serum ferritin, which is a substance that holds iron in the liver and other tissues. A small amount of ferritin gets into the blood, and that reflects the amount of stored iron (Vullo et al., 1997). A normal person's iron level goes up to a maximum of 400. With an ideal treatment

regimen, the ferritin level for thalassemic transfused children should be between 1000 and 2500. A level of iron of between 2500 and 4000 is not alarming but it can cause damage; a level of more than 4000 leads to major complications; while a level of 7000 or more results in heart failure and death (Vullo et al., 1997).



*Figure 4.3* Desferil pump.

According to Georganda (1988), with patients suffering from thalassemia major the pump, specifically, is viewed as the most difficult part of the treatment as it involves daily pain and is, at the same time, a reminder of the illness. Compliance rates with one part of the treatment do not predict the patient's compliance with other treatment aspects (Gerber, 1986). The fact is that with thalasseemics, non-compliance with blood transfusion leads to an immediate drop of the haemoglobin levels, which results in immediate experience of symptoms, whereas the results of non-compliance with desferil therapy are experienced only in the long term. This explains thalasseemics' high compliance with blood transfusion, as opposed to a high percentage of non-compliance with the desferil treatment (Beratis, 1992). However, even with proper and regular treatment, children suffering from thalassemia major usually do not survive beyond early adolescence. Death results mostly from heart failure or complications related to non-compliance with desferil treatment. Due to the frequent blood transfusions they undergo, thalassemia children constitute a high-risk group for HIV infection (Georganda, 1988). Recent advances in medical technology have, fortunately, led to the increased survival of children with severe illnesses such

as thalassemia major. At the same time, terminal illness is still a threat to life expectancy. As such, it severely restricts activity and significantly compromises life quality. Treatment for thalassemia has become increasingly complex, resulting in prolonged stresses upon the child and the family.

Ensuring medical compliance is seen as one of the greatest challenges in the treatment of chronic conditions, and is often interpreted as requiring a one-sided physician-patient relationship, in which the doctor diagnoses and prescribes while the patient gratefully “complies” (Rissman & Zimmer Rissman, 1987). Compliance is likely to become an issue when illness conditions are complex and require changes in the patient’s life-style. Compliance rates have been found to be below 50% among those who have life-threatening diseases (Bergman & Wilholm, 1981).

A study conducted by Ross and Phipps (1986) point out that professionals are more likely to focus on their patients for an explanation of possible non-compliance, than on themselves. Holden et al. (1991) conclude that a symptom’s maintenance may be the result of underlying differences in the patient’s management by the various health workers, while Bloch (1991) suggests that non-compliance should be located at the interface between the patient and the provider system.

### *Expert Frame*

As I have already mentioned, I began giving educational talks to the thalassemia parents at Coronation Hospital in 1994. My lack of experience with serious illness led to a naïve and simplistic view of illness and compliance on my part. Looking back, I think that when I was asked to help with thalasseemics I had no intention of getting really involved. I thought that I would give a few “talks” which would improve things, and that I would then go back to the “real problems”.

That year was my first year as a qualified professional in South Africa. At Coronation Hospital I was trying to get to know the system. I was the first and only resident psychologist, which created enormous pressure in respect of service delivery. From 1994 till 1997 I was entirely on my own and had no colleague with whom I could share my difficulties or use as a sounding board. I was overwhelmed, but unable to relieve pressure anywhere.

Things were difficult in my marriage. It was the second year since immigrating to South Africa. My husband resigned and was unemployed for 6 months, which placed huge financial pressure on me. He became depressed. I was trying to make sense of the new country and the new job, while he kept talking about going back home. I had, as yet, had no time to build South African friendships, and had no support system. The year before, while I was an intern, I had often felt lost and had wanted to give up, but had kept encouraging myself that once the internship was finished everything would be different. I soon realised that the hard time was far from being over.

In my first few months at Coronation Hospital I was bombarded with referrals. Unable to say “no” to any of the referrals because of my need to prove myself to my colleagues, I soon landed up with an overwhelming amount of work. Coronation had no official psychology posts, and when Professor Rosen, the head of the Paediatrics Department, decided to give up a medical post in order to appoint me, it placed me under a great deal of pressure regarding performance. I wanted to prove to him that I was worth that sacrifice. At the point when the paediatric consultant asked for my help in dealing with thalassaemia major families, I was already feeling overwhelmed and frustrated in my efforts to help everyone who needed help. And there were so many. This situation influenced me in looking for a “quick fix” with the thalassaemia families. I thought that a few educational talks would help the patients to improve, the referring doctor would be happy that I had done something and I would be able to move on.

So I started in the expert position, with a hierarchical style of communication, an instrumental approach and a strong need for certainty and structure within the therapeutic process. Amundson et al. (1993) say that these are characteristics of the first-order therapist, and point out that when the therapist adopts a position of “power-certainty”, one of the results is “the loss of alternatives or the subordination of naïve experience to expertise” (p.112).

The therapist who takes an expert position may silence her clients, and her approach may become inflexible and rigid. In my case, setting up a priori goals for improving compliance was a clear indication of my instrumental approach. An expert position and hierarchical style refer to a position of power where the therapist is an

expert and possesses knowledge. The position of knowing creates a power imbalance between the therapist and the client, who is presumably in the not-knowing position. Thus my knowledge of thalassemia major and of compliance problems assured my expert role. Hilton (1997c), speaking about power in therapeutic relationships, concludes that “the client-therapist relationship is an intense, intimate dyad wherein the therapist, in most instances, is perceived to be in control and has the power. The client is perceived to be in a dependent position. There is no real mutuality; the therapist reveals comparatively little of himself” (p. 188). First-order therapy promotes a “therapy of power” (Amundson et al., 1993, p. 111). A first-order therapist perceives herself as an objective observer who sets up goals and, through structural or strategic interventions, changes the observed system (Becvar & Becvar, 1996). The focus of the first-order therapist is on changing behaviour (Anderson & Goolishian, 1990), in this case from infrequent use of the desferil pump to more frequent use.

#### *The Expert's Struggle – First-and-a-half-order Cybernetics*

After several months of educational talks there was no improvement in patients' compliance. At first I became frustrated and angry that no improvement had been achieved. I began to feel that the referring doctor expected miracles from my involvement. I thought that perhaps if I did some more reading I would be able to improve things. I tried harder and read up even more on compliance and on the psychological aspects of illness. Kottler and Blau (1989) refer to specific unconscious strategies which can keep the therapist safe from confronting her failures, the most common being work addiction. The therapist who rarely says “no” (as I could never do) to professional requests, and just as rarely sets aside time for solitude and self-reflection, is prone to self-deception. Such a busy schedule leaves no space for a desirable amount of self-analysis in dealing with failure and promotes denial and a sense of perfection.

At that stage, however, I expanded on my medical and psychological knowledge, hoping to get more ideas for my work with thalassemia major families.

McDaniel et al. (1992) propose a bio-psycho-social model, communicating the idea that all problems are at once biological, psychological and social. They also emphasise a systemic approach in working with medical problems and their contexts. In their discussion of childhood illness, they conclude that there are several factors that are commonly evident: parental guilt, grief over the loss of a “normal” child and its future, developmental issues, fear of “contagion” and, as a result of chronic relations with the medical system, vulnerability to health professionals.

According to McDaniel et al. (1992), when a family has a member with a chronic illness, the family also has a “chronic” relationship with health professionals. This can often lead to parents feeling angry with the health team for not helping enough. The situation can become even more difficult when parents triangulate staff into family conflict. The challenge for the medical family therapist is to listen and support without scapegoating or triangulating against the health team, and also to support other health professionals in their distress over the seriously ill child.

Despite the chronicity and burden, the psychological aspects of childhood illnesses such as thalassemia have received little investigation (Beratis, 1992). Emotional stressors include the child and family’s acceptance of a chronic condition and its life limitations, with recurrent grief, blame and guilt. Nash (1990) concludes that parental denial, fear, and guilt interfere with adequate parenting. The child’s sense of self-esteem may be threatened, as he or she might perceive himself or herself as different from other children. Georganda (1990) emphasises the impact of serious illness on a child’s body image and self-esteem.

One of the growing areas of research explores family interactions in relation to childhood illness (Noll, Swiecki, Garstein, Vannatta, Kalinyak, Davies & Bukovski, 1994; Penn, 1983; Reiss, Gonzales & Kramer, 1986). Seaburn, Lorenz and Kaplan (1992) report that families and patients who have to deal with chronic illness create meanings for their experience, which often evolve over several generations. According to these authors, the development of illness meanings across generations is particularly relevant when a family is facing a genetic disease. Cognitively, the family would need to develop an understanding of the illness and develop

appropriate ways of dealing with it. They would also need to alter their life-style so as to incorporate illness management.

Family instability, the complexity of medical procedures and the patient's personality traits are some of the factors that are likely to interfere with treatment compliance (Beratis, 1992). Secondary gain as well as other resistance themes can also play a major role in recovery. Schoen (1993) found that when they were under a hypnotic trance, 40% of his subjects stated that they were not ready to recover.

### *Fear of Failure*

As my reading progressed, I realised how complex the problem was and that a simple educational approach was not going to be sufficient. As noted by Kaffman (1987), a monolithic belief system in therapy inevitably leads to failure, and I began to doubt whether I would be able to make any difference. Fear of failure surfaced. Failure is seldom discussed in the literature and although it is a common experience in life, it is a neglected area of study in psychology, as Kottler and Blau observe (1989). These authors also point out that the lack of observable progress and self-doubt on the part of the therapist as to his or her effectiveness are indications of failure. At the point where this began happening to me, I failed to examine my own process and the way it was affecting the therapeutic process (Noonan, 1999). My position of expertise had compromised my flexibility and allowed the development of blind spots in respect of unresolved personal issues that were having a negative effect on the process (Amundson et al., 1993).

Looking back, I can see that my initial approach was characterised by too quick an intervention without sufficient planning, which Kottler and Blau (1989) say is likely to provoke failure. They refer to four prevalent factors that cause treatment failures, which are parallel to the factors that I believe led to my initial stuckness. The first factor is lack of knowledge, which was my initial position. The second factor is subsequent to the first: lack of understanding of the real nature of the problem, including the circumstances of the referral. When I started with the thalassemia groups I had very little knowledge of serious illness and compliance, which led me to approach the problem in this narrow way. The third factor refers to the therapist's insufficient alliance with the family, or a weak therapeutic relationship

with the client. Because of time pressure and my overwhelming workload, I did not create sufficient time for developing a bond between the group and myself. Finally, the fourth factor is the therapist's professional transition, which I believe was taking place in my life at that time. The year 1994 was the beginning of my professional career in South Africa, and of the struggle to rebuild my professional image and confidence. My professional development had suffered a considerable blow when I immigrated to South Africa: I had had to re-do my internship, start all over again, and make peace with the fact that I had already spent 6 years building up my professional identity in Yugoslavia.

Self-doubt and frustration eventually led me to start assuming a "not-knowing position", which is one of the characteristics of second-order therapy (Goolishian & Anderson, 1992). Kottler and Blau (1989) make the point that therapeutic failure may provoke anger or doubt about our skills, but that it can also stimulate deeper explorations and understanding. My stance began to shift to a position of relative objectivism (Guba, 1990), where the researcher does not perceive herself as totally separate from the researched and acknowledges her influence on the group. It was around that time that the idea of doing a doctorate entered my mind, perhaps as a strategic move to improve my motivation and create a space for curiosity.

At the beginning of 1995 I decided to look through the patients' files in an attempt to understand the extent of thalasseemics' non-compliance, as well as the complications they suffered as a result of thalassemia major or the iron overload resulting from non-compliance with desferil treatment.

#### *Medical Condition and Compliance of the Participants*

The maximum ferritin level in a healthy person is 400. However, ferritin levels in thalassemia major children are much higher due to the iron overload brought about by the regular blood transfusions. Ferritin levels between 1000 and 2500 are considered "normal" for thalassemia major patients. Children over 5 years of age with ferritin levels below 2500 are considered compliant. The level of non-compliance thus parallels the level of ferritin: the higher the ferritin level the greater the non-compliance. As previously discussed, a ferritin level of between 2500 and 4000 can damage organs; a level of between 4000 and 6000 is alarming; and a level

of over 7000 is considered life threatening (Vullo et al., 1997). In 1993, prior to any therapeutic input, the medical condition of the patients I had seen occasionally or regularly was as shown in Tables 4.1 to 4.3.

Table 4.1  
*Group I: Ferritin Levels*

Patient	Age	Gender	Ferritin level in 1993
N.L.	13	M	5352
A.C. <sup>a</sup>	14	M	6540
R.C.	13	F	8450
N.C.	13	F	5815
N.Ch.	13	F	3387
M.T. <sup>b</sup>	3	M	1080

<sup>a</sup>A.C. and R.C. are siblings.

<sup>b</sup>M.T.'s ferritin level should be around 500 for his age.

Table 4.2  
*Group II: Ferritin Levels*

Patient	Age	Gender	Ferritin level in 1993
S.G. <sup>a</sup>	10	F	4671
Z.A. <sup>b</sup>	11	F	4712
K.A.	6	F	4149

<sup>a</sup>S.G. contracted HIV through blood transfusion in 1992.

<sup>b</sup>Z.A. and K.A. are siblings.

Table 4.3  
*Ferritin Levels of Older Patients*

Patient	Age	Gender	Ferritin level in 1993
V.H. <sup>a</sup>	16	M	11500
Z.S. <sup>b</sup>	23	M	9748
M.P. <sup>c</sup>	19	M	4200

<sup>a</sup>V.H. was seen regularly for individual therapy. His spleen was removed in 1991 and he suffered a heart failure in 1993, which he miraculously survived.

<sup>b</sup>Z.S. was seen infrequently. He suffered from diabetes as a result of iron overload.

<sup>c</sup>M.P. was seen infrequently.

What was clear from these results was that all of these patients had major compliance difficulties, and some were already in either the alarming or the life-threatening category.

Looking at the first group, three out of six children had ferritin levels between 4000 and 6000, which is the alarming category, and one of the six was in the life-threatening category with a ferritin level of over 7000. All three girls in the second group had ferritin levels just over 4000, but they were a much younger group, and at their age, ferritin levels in excess of 4000 were very worrying. According to the doctors, 16-year-old V.H. was beyond help in respect of his ferritin level, which was over 10000, but he needed support. His family apparently never accompanied him to the hospital, he often struggled with transport, and on numerous occasions other parents shared their food with him as he had no pocket money. The eldest thalassemia patient, 23-year-old Z.S., was also in a life-threatening category and, according to the doctors, beyond help. M.P., 19 years old, was in the alarming category with a ferritin level of over 4000.

At that stage, I made no conscious connection between my personal struggle in relation to being re-rooted and my striving to visualise my future in a positive light, and the thalasseemics' struggle to project themselves into the future. I still had to accept my new life and learn how to make the best of it, just as they had to accept life with illness and still make the best of such a life. We had no idea as yet to what extent we would influence each other's lives. At that time I saw them as just another hospital referral I had to deal with, and they saw me as another "doctor" who knew better than they and did not really care. Both sides expected little from the contact, and both thought it would be a short-term experience. I thought that after a few meetings it would be over; and they had experienced so many changes with doctors that they saw me as just another one passing briefly through their lives.

I have often thought about when it began to look different, and why. Perhaps it started changing when I began to struggle and, as a result, to self-reflect. Perhaps it was my curiosity, or perhaps it was my characteristic of not giving up easily. My family used to describe me as stubborn, and as "going through the wall". But it was those very characteristics that ensured my survival in my family. Perhaps these personal characteristics were pivotal in my becoming more involved as things grew difficult, instead of giving up. My decision to do a doctorate on my work with thalassemia families was another way of motivating myself to find a more constructive approach and to become more deeply involved.

Although by now I realised that my educational approach was unsuccessful, I did not see it as a failure – yet. I was too busy and made no space for self-reflection, so I just kept going. I was totally unaware of my personal issue with failure and my difficulty in confronting my vulnerability. So I dealt with my lack of success as though it was not especially important. Denial is such a powerful strategy, and so helpful when one has no emotional space to deal with anything. I think that I was just beginning to slowly pick up pieces of myself after the shattering experience of immigration, and I was emotionally too vulnerable. So at that first step, I protected myself with denial of my failure.

The stage of first-and-a-half-order cybernetics began in 1995, characterised by extensive reading, deeper involvement, and a different approach. I shifted into a less controlling position, showed more curiosity about the mothers and children's stories, took a less hierarchical role by assuming a "not-knowing position", and created space for their involvement. However, the process had not yet reached a consistent level of second-order therapy. I was still unaware of my own participation and of how my personal self was affecting my professional self. But my uncertainty provoked less restricted conversations. The monological experience shifted to dialogical experience, and new voices were composed (Penn & Frankfurt, 1994).

#### Thalassemia Voices: 1995

##### *Hospital Context*

The first group of mothers that I saw usually consisted of five mothers (there were altogether six mothers, but one of them did not come regularly for her son's transfusion). At the beginning of 1995, most of the conversations seemed to be about the mothers' frustration with the space in which the transfusions took place, and with the doctors. In 1995 the health authorities' decision to make Coronation a specialised mother-and-child hospital meant that major renovations had to be done, which affected everyone. I was moved three times in 2 years. The hospital was in a huge mess, with building material everywhere. The ward in which the thalassemia patients were transfused had to be renovated, and the children were transfused wherever there was a space – invariably a different place or ward each time.



*Figure 4.4* Mothers in the ward during their children's transfusion. (All the families have granted me permission to use the photograph for this dissertation.)

Coronation Hospital is an academic hospital, which means that except for the consultants, most of the doctors are in training. Those who are specialising in paediatrics are called registrars, and they are rotated through different departments every 2 months in order to get exposure.

However, for chronic patients such as the thalasseemics, this means that no sooner do they get used to one doctor dripping them than he or she moves to another clinic and a new doctor appears. Fortunately, the consultant remains the same, so Dr. G. was a sort of executive who made the final decisions. However, dripping is the job of junior doctors, who are constantly rotating. The principle of rotation also applies to the training of nursing staff, which means that very few of the staff remain constant for chronic patients such as thalasseemics. Before I began my work with thalassemia patients I had never given much thought to how the constant rotations affected the patients, but as I listened to their stories I realised that they had a major impact on their motivation. Coping with the uncertainties of the hospital system seemed to drain enormous energy from children and parents.

I can see now how such a system affected everyone, including myself. I, too, found it difficult to see different faces every time I went to the ward. It meant that I had to introduce myself and explain my role every few weeks. I began to understand why, in the first few months of my “lectures” and talks, the thalasseemics were so neutral. I think they had learnt not to get too excited, because people came and left so often in their lives. The rotations also made it difficult for me to collaborate with the registrars. The only option was to schedule regular meetings with the consultants who were responsible for the thalassaemia clinic. In 1994 there were two consultants, but by 1995 one of them had left. He was said to be about the fifth consultant who had come and gone in just a few years. As far as the registrars were concerned, I calculated that over a period of 10 years a thalassaemic child would be pricked by probably sixty different registrars.

I suppose it is then not difficult to see why issues in relation to the medical staff, space and treatment dominated our initial conversations.

### *Rising Voices*

After I decided to start a research study with the thalassaemic children and their families, I introduced the idea to the group at one of the sessions at the beginning of 1995. I also broached the idea of closer collaboration between the medical staff and myself.

*Ther.:* The first time I heard of thalassaemia was from one of the paediatricians last year. I was curious and I got some literature, but I found very few studies on thalassaemia done by psychologists. And when I phoned around I found that no other thalassaemia group in South Africa had a psychologist involved. So we here are unique. I also thought that writing about these sessions would create more awareness and help others dealing with thalassaemia. I would like to learn more from you about the difficulties and see how we can improve things, whatever they are. I have suggested to Dr. G. and Dr. M. for the three of us to meet on a regular basis and I am hoping that it will lead to better communication between all of us. I remember that one of the thalassaemia parents mentioned the problem of poor communication. I was also thinking that maybe you had a lot of space to discuss bodies and medical problems, but very little space for anything else.

*D.T.:* When I am putting it (*the pump*) on it is very hard. His skin is so hard... it just won't go in.

*Ther.:* One of the mothers from the other group described to me that putting in the pump looks like she is going to murder her child.

*V.L.:* That is how it looks when you are putting the pump in.

Further on in the same session, discussion moved to the group's experience of times they associate with better medical care. In this discussion it became evident that the group held incorrect beliefs about HIV transmission. The issue of death was introduced. I made no attempt to find out more about Mohammed's death, avoiding an emotionally charged conversation and protecting myself from confronting my weakness (Berg, 1985). Instead, I focused on HIV and suggested some more "lectures". But the group had their misgivings about the usefulness of such an approach.

*D.T.:* I like that we have a psychologist.

*V.L.:* The group in Johannesburg General – do they have a psychologist?

*Ther.:* No, I phoned to several different centres around the country. I believe that Coronation is the only place.

*V.L.:* But they have better service than we do. We used to have ultra sound, cat-scans. We had Dr. R., she did a lot for us.

*D.T.:* But from the time she left we haven't had any Christmas party or getting together. It was nice – informal get-together and see each other. The last one was 2 years ago.

*D.T.:* We used to invite doctors and their families.

*N.C.:* Dr. G. had us for a party in his house.

*V.L.:* I think that was just after Mohammed passed away. We were very upset... and also they didn't notify us that he was HIV positive. They said at the funeral that they were not allowed to open the coffin for that reason.

*N.C.:* I think it is because it may spread.

*Ther.:* HIV doesn't spread though air, or touch. Maybe we should organise a talk about HIV?

*V.L.:* Yes.

*D.T.:* Especially with transfusion. You never know if you come next day and your kid may get it.

*N.C.:* We had meetings and lectures. But I don't know how useful.

*Ther.:* What do you mean?

*N.C. (turning to V.L.):* Remember when Dr. S. gave a talk. He spoke of desferil costs. It is not that we don't want to know the costs, but he is trying indirectly to tell us that everyone is doing us a great favour, you must appreciate what we are doing for you. And we do. We don't have money to go private. But the thing is this – we want to stop the costs. If we can find the cure tomorrow it will stop that cost. That is what we are interested in. So if you are going to have a talk and invite him it is not going to be of any benefit.

*V.L.:* Look we don't mind. It is just...

*Ther.:* I had in mind people from the Blood Bank. But in respect of Dr. S., I understand your point but I am not sure that I can control who can or not take part in that talk.

*V.L.:* We understand. Maybe if these other people come it will be good, even if Dr. S. gives his usual talk.

In the next segment the group discuss their frustration with the renovations and general chaos in the hospital.

*D.T.:* Today M. (*her son*) didn't want to get to bed. He cried. He just wanted the old place.

*N.C.:* I think it is quite affecting the kids.

*D.T.:* And he was crying so much.

*N.C.:* We know this ward is temporary. We don't want to be difficult.

*V.L. (speaks to therapist):* Can you find out for us how long it will be like this (*referring to renovations that had been going on in the hospital going for a few months*)? It would be easier if at least we knew for how long.

*Ther.:* I suppose it is difficult if you have been coming for long and got used to a certain place. (*When the renovations started, we were told it would be just a few months, but by the time this conversation took place, they had been going on for double that time. We were told that the hospital had run out of money and were waiting for more money.*)

*V.L.:* The kids are upset. They are in ward 2 and they are so much older than the other kids. They are not comfortable.

*N.C.:* Now they really feel like they are in hospital. They see all these sick kids... I myself, I feel upset.

*V.L.:* We should have a separate space.

*N.C.:* R. was very upset last time. The drip was not working and we couldn't get a doctor.

*Ther.:* It sounds difficult. How do you survive all that?

*N.C.:* You have no choice... you are busy all the time.

In this discussion it became clear that their coping mechanism was similar to that of the therapist: no time for self-reflection, which led to self-deception and denial. This became clearer to both sides as the process continued and some more stories on survival were shared.

In the next passage, the group express their difficulty in communicating with the hospital system and invite the therapist to take the role of messenger.

*D.T.:* We never know what is happening in the hospital and the hospital does not know how we feel about certain things. And you may know both.

*Ther.:* Are you saying that you need me to communicate certain things between the group and the hospital staff?

*N.C. and V.L.:* Yes.

A little later the group spoke of their difficulties with Dr. G., a medical consultant, and attempted to create an alliance with the therapist against the doctor. McDaniel et al. (1992) point out that the medical family therapist needs to listen to the patients without allowing herself to triangulate against or scapegoat the medical team.

*N.C.:* You know... you don't come and just sort it out and finish. She (*Dr. G.*) does not encourage you. She has sort of negative attitude. You have a different attitude, you show us that you care. Kids also take an interest in what you say.

*D.T. (interrupting):* They feel comfortable with you... but the more she is negative, the less they want to do it (*the pump*).

*N.C.:* You know she made a statement bluntly in her face (*referring to her daughter, R.*) that she is not using the pump. I am the mother and I know. You know, that put R. off Dr. G., you know, when she (*Dr. G.*) told her that she is lying...

*Ther.:* Why do you think Dr. G. reacts like that?

*D.T.:* Maybe she gets angry that we are not compliant. I think that maybe she feels like she cannot help us or something.

*Ther.:* You mean helpless?

*D.T.:* Ya...

In the next discussion a month later, the conversation focused on the issue of communication and the paradoxical messages that were provoking frustration and anger within the group. Nehemkis (1986) notes that results from numerous studies indicate that relationships with medical staff, especially nursing staff, are critical in influencing patients' acceptance of treatment. He goes on to describe how staff can create incongruent or double bind communication with the patient, where on the one hand the patient is expected to behave independently, but on the other hand information that would promote more independence is restricted. Bias and expectations on the part of medical staff may be negative factors in compliance issues. Their misperceptions can result in selective attention to certain complaints. Klinge (1993) recommends that closer attention should be given to staff-patient communication, while Nehemkis (1986) suggests that communication difficulties can be addressed through programmes designed to sensitise medical staff to compliance issues and communication skills.

*V.L.:* The nurses don't see much of us. We do everything.

*N.C.:* They are not there to help us. They send us trainee sisters. Then we first need to teach them and then they didn't like us to tell them... but they didn't know what is going on.

*V.L.:* They would tell us that they don't know anything about thalassemia. And that everyone said that it was the worst clinic to work at.

*D.T.:* Then we help them. There are certain things we are not allowed to do. We cannot fill in the desferil. So they will do it. But when we call them for things like that they become very rude.

*N.Ch.:* In the past we never used to trouble them. We used to do all by ourselves.

*Ther.:* When was that?

*N.Ch.:* When we were in the ward upstairs. They left us alone. Then they changed the ward, then no ward. We were never sure where we are supposed to be... drips never set up... moved around...

*D.T.:* They tell you if that one (*ward*) is empty, go there. Sometimes by eleven o'clock the ward is not there. Then if you tell something they get upset and say you expect this good treatment.

*V.L.:* Like we belong nowhere. We are an invisible nuisance. They treat us like they don't see us.

*Ther.:* Why do you think the sisters behave like that?

*V.L.:* I don't know... I think that changes in the hospital made everyone frustrated. But we would never ask for help unless it is necessary. That is how we learnt to do all the stuff. So we wouldn't depend on them (*the nurses*). They would make comments, like we expect too much and we are getting things for free. To ask them for a needle is a mission. And if you get it yourself they get upset – why you are touching our things? Once transfusion is finished you try and forget all these things.

*Ther.:* Are you saying that you got a message from their behaviour that you should be more independent, but when you did so they got upset?

*V.L.:* Exactly.

*Ther.:* Well, maybe it would help if we got permanent nurses once we get a proper ward. I have discussed the ward with matron and they promised that once the renovations are finished the thalassemia patients will get that ward downstairs, which will be exclusively for that.

*D.T.:* That would help us.

*N.Ch.:* Then we could bring some stuff from home and make it more comfortable for the kids. You know... like pictures, toys...

*Ther.:* Sounds good. Well that is something to look forward to.

In the next session the group discussed doctors' rotations and how these affected them. Gerber (1986) points out that those health professionals who "provide consistent care within the caring relationship do seem to influence higher compliance

rates in their patients” (p. 16). Hanson (1986) suggests several essential factors which may improve compliance:

1. Information from the doctor should include reasons for procedures and the options available.
2. The doctor should spend an adequate amount of time communicating with the patient.
3. The doctor should use ordinary language, which patients can understand.
4. A collaborative rather than an authoritarian style on the part of the doctor would have a positive impact on compliance.
5. Establishing good relationship with the patient is essential for compliance.
6. Using forceful or negative communication to increase compliance leads to short-term progress, but in the long run leads to non-compliant, defensive reactions from the patient.

*D.T.:* The kids get nervous – not comfortable. The doctors treating them, you know, the new ones don’t understand them. And then when the kids get frustrated and scared, they are rude to them, not understanding that for children to get pricked five, seven times... it is frustrating... scary. And you cannot tell them to shut up and let me prick you some more.

*V.L.:* We wrap them in sheets, just for the doctor to find the vein.

*D.T.:* We would hold the child, wrap him in sheets... I do understand they (*the doctors*) must do their job. But not like that. That is not pumpkin that they are treating. If I go to the doctor, Zana, I am also scared of the needle. I don’t like to be pricked. The kid is frustrated – it must be difficult. I hate seeing that.

*Ther.:* And how about doctors you did or do appreciate? Are there any?

*D.T.:* There were some. They first come and talk to children, make them comfortable. You remember (*talking to V.L.*) the one with brown hair, he was very nice, gentle with children. They didn’t fight him.

*Ther.:* So what is the difference?

*V.L.:* Humanity. To show us that they care. If they have loving feelings for you and the kids you think, “OK, you will be gentle – they will be fine”.

*D.T.:* You know there was a doctor that pricked M. (*her son*) eighteen times. Eighteen times! (*Tearful.*)

*V.L. (interrupting):* We tell him to leave him alone. We will find another doctor or we will go home.

*D.T.:* And it was not even a young doctor...

*V.L.:* We had a female doctor once. She never treated children before. The fifth time she tried to drip N. (*her son*), he said to leave his hand alone. Every 2 months, a new registrar. The kids just get used to one and then the new comes in.

*Ther.:* And how do you deal with a situation like that?

*V.L.:* Well even if they (*the kids*) are right, you cannot be rude to the doctor. We won’t show it to the doctor that the child is right.

*Ther.:* And how do the kids react to that?

*N.Ch.:* They get very upset when you do that. She (*her daughter*) says that Mammy doesn't care. I tell her that you cannot insult the doctor like that.

*V.L.:* You know, N. (*her son*) won't eat the whole day, he wouldn't talk to me.

*Ther.:* And does it affect putting the pump in?

*V.L.:* Well, when he is difficult then you must grab him and do it. I strap him, sit on his thighs, Daddy holds his hands, you grab him and prick him.

*Ther.:* It sounds like you find yourself in a difficult position. Trying to pacify the kids and at the same time making them see the doctor's side.

*V.L.:* Yes. You try to please the children and the doctor. We tell them not to be rude to the doctor. We tell the doctor, "Sorry, and he had so many pricks and he is a bit afraid." And ask him (*the doctor*) to let me calm the child and we will call him back.

*D.T.:* Some don't take it well. They say I am not good enough doctor for you.

The issue of poor communication between staff and patients, unreasonable expectations from both sides and lack of understanding of the complexity of compliance, prompted me to do a workshop for the Paediatric Department. The workshop was attended by paediatric consultants, registrars and medical students. We addressed issues such as lack of training in how to deal with emotional issues, fear of failure, feelings of inadequacy and helplessness when dealing with chronic illness. The interesting conclusion that came out of the workshop was that when a consultant is faced with the necessity of discussing an issue that may provoke a highly emotional reaction from the patient, he or she often passes the responsibility on to the most junior staff. Junior doctors said that they found this highly uncomfortable and often tried to pass the responsibility on further, to the nurses. They were of the opinion that this kind of discussion with the patient should be the responsibility of the most senior consultants. However, both sides agreed that everyone was behaving as if a hot potato was being passed quickly from one person to another, and that this served as a protective mechanism to shield them from patients' strong emotional reactions. William (1992) found that medical students were not encouraged to discuss their feelings and anxiety in relation to illness and dying, but were given the message to bury it (as it were) and forget about it. Medical training that discourages one from sharing vulnerability negatively affects the clinician's ability to remain sensitive and available to the emotional processes of the patient and family attempting to cope with serious illness and dying (Rolland, 1994).

One of the doctors explained that they are trained to cure, so dealing with chronic or terminal patients makes them confront their limitations as doctors. According to McDaniel et al. (1992), most physicians are trained to cure disease but not to treat and remain sensitive to the experience of illness. Kottler and Blau (1989) speaking of the difficulty of facing up to our failures, say:

Because doctors do not discuss their mistakes, I do not know how other physicians come to terms with theirs. But I suspect that many cannot bear to face their mistakes directly. We either deny the misfortune altogether or blame the patient, the nurse, the laboratory, other physicians, the System, fate – anything to avoid our own guilt. (p. 15)

Spiegel (1993) wisely advises: “Cure when you can, comfort always and view it as a part of your job, not as a sign of failure” (p. 228).

Back to the process with the group, in one of the sessions a mother told a story which I saw as an attempt to relieve her guilt by passing it on to the child. The issue of guilt is a common theme in families with inherited illness (McDaniel et al., 1992).

*Ther.:* How are the kids coping with illness?

*D.T.:* Some days you just have no answer for them. He says: why must I do it (*the pump*)? Put it in yourself and see how it is. Why me? Some days we fight a lot to put the pump in.

*Ther.:* And what do you tell him?

*(Everyone laughs.)*

*Ther.:* What is funny?

*V.L.:* The story we tell them. You know I tell N. (*her son*) that he wasn't there on time when God was giving blood. Now we must fetch your blood from the blood bank. I ask him does he remember the time he come to earth. I ask him: “Do you remember when you were born and in God's house they were giving blood... and you were playing and when your turn come around you were not in the queue, so you lost on the blood.”

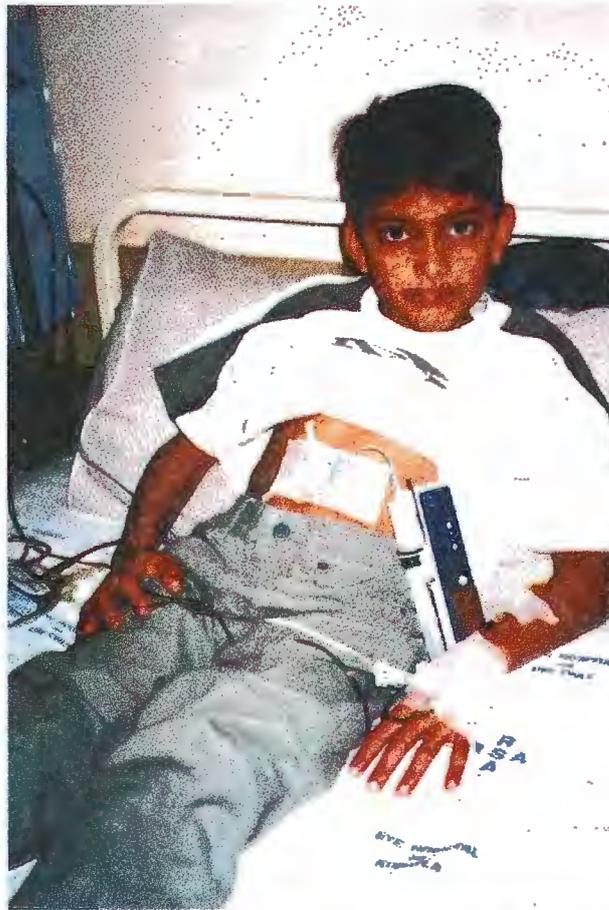
During the first part of 1995, the group spoke very often of their struggle with uncertainty and helplessness. I was, at the same time, struggling to make sense of the totally chaotic hospital, being shuffled from one office to another, coping with so many referrals. When the group complained, I felt responsible and I would try to take action to make things easier for them. I successfully negotiated a specific ward allocated exclusively to thalassemia patients in need of transfusion, which is still

operational. However, with other issues the resolution was short-lived. After a meeting with the paediatric matron, the thalasseemics were given two, supposedly permanent, nursing sisters (one learns that nothing is permanent, especially in the hospital system.) A year later that matron left, and the one who took over simply said that the request was not reasonable. While it was probably not reasonable for the system, it made a huge difference to the thalasseemics. A close relationship developed between them and the two nursing sisters during that year, and there were no problems with communication. The nurses got to know the patients and parents, and made suggestions, comments or observations that I found very useful. However, things went back to the “normal chaos” when the two nurses were transferred to another ward and we had student nurses, and the same chronic problems made their appearance all over again.

As Ludwig (1971) observes, the institution can become an unwitting conspirator to the patient’s chronicity. The process of chronicity “may be regarded as a joint enterprise between patient and hospital” (Ludwig, 1971, p. 15). He points out that hospitals often foster less responsible behaviour and do not encourage decision making by patients. Patients may also be exposed to a number of double messages concerning their responsibility. Instead of taking responsibility for the patient, Ludwig proposes that the treatment approach be designed to help the patient exert her or his will. He argues that it is unlikely that treatment will be successful unless the hospital makes space for the patient to do this, and to learn how to take responsibility. Skynner (1989) says that government services that deal with disadvantaged clients are themselves demoralised and defensive. They resist change, show a high staff turnover, are secretive, restrict communication, are controlling in an infantilising way, are rigid and dislike opposition or criticism. Systems with these characteristics tend to maintain patients’ dysfunctional behaviour.

For the thalassaemia group, the most difficult part of their treatment was undoubtedly the use of the desferil pump, with a needle which the parent has to push into the child’s stomach every night in order to remove excessive iron. The child has to sleep with the needle in his body every night, for eight to ten hours, in order for the medication to slowly dissolve. I struggled not to close my eyes or look away when they pulled up their shirts to show stomachs and thighs that looked like

battlefields, full of dark circles, blue marks and needle pricks. When the stomach area becomes full of deep knots, which develop because of the constant pricking, the parents are advised to inject the thighs with the desferil pump. But this is easier said than done. When there is a screaming child pleading, “Mammy, don’t put the needle in!” it is easy to understand why there is so much non-compliance with this part of the treatment. Parents say that it is difficult to explain to a small child that this is for its own benefit, and describe how guilty they feel about hurting their child. So many parents get persuaded by a child’s tears not to put the pump in, but the painful consequences of this action are visible only in a few years’ time – and by then it is usually too late to make things right again. The amount of iron that accumulates in the meantime cannot be removed and soon leads to different medical problems and, finally, death.



*Figure 4.5* Thalassemia patient on transfusion and desferil pump. (The patient’s family have granted me permission to use the photograph for this dissertation.)



*Figure 4.6* Scarring on patient's thighs caused by use of the desferil pump. (The patient's family have granted me permission to use the photograph for this dissertation.)



*Figure 4.7* Scarring on patient's stomach caused by use of the desferil pump. (The patient's family have granted me permission to use the photograph for this dissertation.)

In one of the sessions they spoke of their difficulty with people's curiosity.

*V.G.:* And funny enough, people are so inquisitive. They want to see the pump, they stick around and we want them to go home. The child tells you: "Please tell them to go." And it makes you so angry and emotional. I tend to be rude and then regret it and apologise.

*Ther.:* How do you understand people's curiosity?

S.A.: It is our neighbours. They all come. They keep saying, "Oh, shame how is your little one?"

V.G.: People say that because they come so often to the hospital and have to pump every day, so they must be used to it. I want to scream: "For God's sake! No one should ever get used to that!"

S.A.: I could never take that. You think in the beginning it is just a few injections, but it is an everyday thing. Like yesterday, there was a friend that came and he says, "How is R. (*her husband*), and how are the kids?" I say fine. He says, "Are they still sick, going for treatment?" I just wanted to give it to him. I felt like I didn't want to talk to him. Then I thought, why are you like that, he was just trying to be nice and ask you. But at that stage I was upset.

V.G.: What I find strange about human beings... like friends ask me: "Hi V., how are you, how are the kids? How is your sick daughter?" They classify your child as sick. You know... it all depends on my mood. But at times you just want to walk away.

Ther.: What do you mean by moods?

V.G.: It all depends on how my mood is. I would say, quickly, "She is fine" and change the topic. That is when I don't feel emotionally stable and I don't want to talk about it. But when I am fine then I would elaborate.

Ther.: So you are saying that when you feel vulnerable it is difficult to talk about sensitive subjects?

V.G.: Yes.

Ther.: What about your family?

V.G.: No. With family it is easier, I can put them straight (*laughing*).

S.A.: My family takes advantage of me.

Ther.: So how do you deal with that?

S.A.: I don't. I keep quiet. I just take it all. I have always been like that.

Conversations with the two oldest patients, Z.S. and M.P., started at the beginning of 1995 in a relatively neutral tone, but unexpectedly, and in a very short time, they became highly emotional. I soon learnt that talking about the pump or just asking simple questions about the family could lead to very painful issues. Those conversations made me feel like I was walking in a minefield, with invisible bombs ready to explode at the smallest touch.

Ther.: Your ferritin level (*speaking to M.P.*) is not great, but your sister's is almost double yours. And she is only six.

M.P.: Mom puts the pump in for her.

Ther.: Does that mean that she is having difficulties putting the pump in?

M.P.: She tries to. But my sister cries and jumps around. We are not putting it in consistently... you know...

Ther.: Why are you saying "we"?

M.P.: Because I try to help Mom.

Ther.: What about Dad?

M.P.: He doesn't get involved. He gets scared. His hands get shaky.

*Ther.:* What makes it so difficult?

*(Silence.)*

*Ther.:* What would your Mom say if she was here?

*M.P.:* She gets home and she is so tired. And sometimes I am not there to help her.

*Ther.:* And if you are not there she cannot manage?

*M.P.:* Ya... So during the week you cannot go out much.

*Ther.:* So you don't go out much because you feel responsible to be there?

*M.P.:* Yes. But we are getting it right.

*Ther.:* So two of you are thalassemia major. Are there any other kids?

*M.P.:* It is only two of us. My cousin passed away – M.P. senior. I am M.P. junior.

*Ther.:* When was that?

*M.P.:* It was 7 years ago. He was 17 when he passed away.

*Ther.:* And what about your family, Z.?

*Z.S.:* My sister is minor (*thalassemia minor*), she is normal and my other brother is also normal.

*Ther.:* Is your brother younger?

*Z.S.:* Yes. But he looks older because I am not so developed. I had a big brother, R. He passed away.

*M.P. (looking anxious, changing the subject):* I am the eldest but the spoiledest (*nervous laughter*).

*Z.S.:* My big brother could get away with the murder.

*Ther.:* Why was that?

*Z.S.:* He was born after 12 years of my Mom trying to get baby. He was very special.

*Ther.:* It must have been terrible for your parents to lose him?

*Z.S. (looking tearful):* That was the most difficult time for my family. And then 6 months after my brother died, my father died of a heart attack. His sixth heart attack. We are a sick family, but strong.

*Ther.:* Is your mother worried about you?

*Z.S.:* I think so. She is scared.

*(Silence.)*

*Z.S.:* Our mothers used to get together and discuss it – like, we give them grey hair, or we don't go to school. There was this other girl. She passed away after his (*M.P. 's*) cousin. She was 13 years old...

*(Silence.)*

*Z.S.:* My mother doesn't come (*to the hospital*) any more after my brother died.

*Ther.:* Is it important for you to have someone from the family at the hospital?

*Z.S.:* Well... yes. But with my mother she cannot.

*Ther.:* Your family had a lot to cope with.

Z.S. (*tearful*): Yes.

(Silence.)

Z.S.: This is why I stopped the pump. It was too much...

Ther.: You felt, like, what was the point?

Z.S.: There was only 2 years' gap between me and my brother. There was a strong bond.

(Silence.)

Z.S.: It is difficult to forget (*tearful*). You are trying to get in grips with life... but you can never forget.

Ther.: Do you talk to anyone about those feelings?

Z.S.: No. It would make Mom more worried.

(Silence.)

Z.S.: I am fine.

Ther.: And your wife? (*Z.S. got married at the age of 19.*)

Z.S.: She spoke to me. That I cannot continue like that (*not using the pump*). I agree, but it is difficult to get back to normal. I am trying to use the pump again. It is only human. You cannot cry about it. You try your best.

Ther.: It sounds like you need a lot of courage to continue.

Forgetting and remembering came up frequently. The patients and parents either spoke of excessive remembering, like Z.S. about his brother, or forgetting very quickly, as when one of the mothers described how they forget hospital trouble as soon as they leave. Remembering and forgetting are indispensable to human experience. According to Boscolo and Bertrando (1993), if the balance between remembering and forgetting is disturbed, the ability to adapt to the environment decreases. Excessive remembering or forgetting can acquire pathological significance, while if the past is blocked it can lead to the future being in chains.

In individual sessions with V.H., who had the highest ferritin level of all, conversations often focused on the pump. On several occasions, V.H. mentioned patients who had died.

V.H.: My H.P. is good. My mother would be happy. If you use the pump you find the difference in haemoglobin. I started using the pump again.

Ther.: So how long was it that you didn't use it?

V.H.: Last time I used it when R. (*Z.S.'s brother, who had died 2 years previously*) and Z. (*Z.S.*) gave me a lecture on pump. It was about 2 years ago.

Ther.: And what made you decide to use it again this time?

*V.H.:* I had an awful dream. I am driving a car and all of a sudden my mind went blank and then I crashed. I woke up in the hospital... pipes... plasters... and I think it is maybe a sign, you know. So I don't end like that.

*Ther.:* Like when you don't use the pump and you end up in the hospital?

*V.H.:* This is why... I woke up in that hospital and it is just there (*the pump*). So I think but what is it doing there? My pump should be at home. The sister says that it is a hospital pump.

Further in the same session he spoke about dagga abuse. Taylor and Aspinwall (1990) describe how chronically ill patients use coping strategies of avoidance or escape, characterised by the use of drugs and/or alcohol, to alleviate stress.

*V.H.:* I will be honest with you. I did try. I had problems with my sister. All of them nagging, because of my friends. I tried to relax my mind. As I took it I was totally normal, I forgot all about it – this problem with my sister. I didn't think of that nagging.

*Ther.:* So smoking dagga calmed you down?

*V.H.:* It is not really a drug. You know mandrax? My sister told me that I will go to mandrax.

*Ther.:* You don't think that way?

*V.H.:* No. I believe that I can leave smoking tomorrow. And I only smoke once in a while.

*Ther.:* I wish we could get you addicted to the pump instead...

*V.H. (laughing):* No, you cannot get addicted to the pump. But my sister, ouf, she goes on and on.

*Ther.:* Maybe she is worried about your health and that is why she is upset. She is trying to tell you that you must take care of yourself. Why would she be upset unless she cares for you?

*V.H.:* She heard from someone about dagga and went to my mother.

*(Silence.)*

*V.H.:* But I will take my medication.

*Ther.:* Hmm... how often?

*V.H.:* Every day.

*Ther.:* I don't know. Can you do that? After not doing it for so long?

*V.H.:* We can make a deal. I will tell you when I put it.

*Ther.:* Shall we draw up two-weekly programmes and you can write down when you use the pump?

*V.H.:* No problem.

He never brought the programme back, but said that he had been using it a few times a week. Several weeks later he said that the pump was not working, and he never brought it in for repairs in spite of constant pressure from Dr. G. and myself.

In one of the subsequent sessions, V.H. spoke openly about death and dying. The roller coaster of emotions began with anxiety, distress and fear of losing control (Framo, 1992). My own emotional struggle provoked a number of the defensive reactions mentioned by Langs (1997): interfering with the patient's narrative by interrupting with questions or comments unconsciously designed to eliminate intolerable content; failing to understand the underlying meaning of the patient's narrative and focusing on the surface meaning; failing to identify death-related trigger events; and intervening in a manner that discourages the patient from looking at such events.

*V.H.:* My girlfriend said that I can kick the bucket if I don't use the pump.

*Ther.:* You mentioned earlier that you were not sure if your mother wants you to live or cannot wait – you said – for the whole thing to be off their chest. Are you unsure if she cares?

*V.H.:* I think doctors care. Dr. G. told my mother to put the pump for me. But she never does. You care. You give us an opportunity to speak our hearts out. Who will give you that opportunity today... nobody... nobody.

*(Silence.)*

*V.H.:* When you come to the ward to see me – you smile – you have a broad smile. Then I know – you care.

*Ther.:* Maybe I do smile, but I am not sure how to deal with the pump story. I don't want to be too pushy because you may start lying about it. But I struggle to leave the subject, then in a way it is like I don't care.

*V.H.:* When I am upset I just listen to music. I feel better. But I cannot go to my sister – she just goes on and on...

*(Silence.)*

*V.H.:* I was cracking a joke with them (*his family*). They said that they must tell me that they love me and they don't want to see me in a coffin... and they must cry. They don't want to lose me now... before we celebrate my twenty-first birthday.

*Ther.:* When is that?

*V.H.:* Next year in June.

*Ther.:* Are you saying that the focus point is twenty-one? What is going to happen after that age?

*V.H.:* No. They are not going to lose me. Maybe they are going to lose me when I am a hundred.

Throughout 1994 and the beginning of 1995, when I met the children's group, we mainly played games. It was from the middle of 1995 that I invited the older group for some "talk time". In one of the sessions, the children discussed the time factor in relation to "outsiders" in the group. In our daily lives, a person lives in her or

his individual time, from which she or he establishes links with the individual times of other people, groups or institutions. Boscolo and Bertrando (1993) hold that each of us needs to adapt to inevitable differences between “individual time” and “individual times”. These authors point out that human time is co-created through interaction, and if the times of the therapy system are not coordinated with human time, it may prove difficult to develop a fruitful relationship with the client. The coordination of emotion, meaning and individual times is a significant factor in developing a therapeutic alliance. At that time, I assumed that “knowing” the group for just over a year was a long enough time, but the following conversation made me aware that a time span of a year had a different meaning for patients who had been attending Coronation for over 10 years.

*Ther.:* Who is fighting the most in the group?

*(Everyone laughs.)*

*A.C.:* Those two (pointing at *R.C.* and *N.L.*).

*Ther.:* What about the rest?

*R.C.:* He never talks (pointing at *R.A.*). He reads all the time. He does not talk to us.

*Ther.:* Are you OK that he is so quiet?

*R.C.:* Well, you know what, we have been together for a long time. They (*referring to R.A. and his family*) are the new in our group.

*Ther.:* What do you mean?

*R.C.:* Him and his mother came into the group only recently.

*Ther.:* How long is recently?

*R.C.:* A bit more than a year. I think about 15 or 16 months.

*Ther.:* So after 15 months he is still the outsider?

*(Everyone laughs.)*

*R.C.:* They are just new to us. He is also shy and we only meet every four weeks.

*Ther. (looking at R.A.):* So where were you before?

*R.C.:* He was in another group. Some groups don't get along, then people change the group and they come to the other group.

*Ther.:* And what happens when one joins another group?

*N.L.:* Well, if you are quiet you won't make friends.

*R.A.:* I am not usually so quiet. It is just here.

*Ther.:* What will it take for you to be less quiet?

*R.C.:* He is just not used to us.

*Ther.:* And how do you think that can change?

*A.C.:* We must talk to him more, then he will talk to us more.

*Ther. (to R.A.):* And how do you think it will make you feel if they try to talk to you more?

*R.A.:* More part of the group.



*Figure 4.8* One of the groups of children with Dr. G. and myself at the Christmas party in 1995. (All families have granted me permission to use the photograph for this dissertation.)

#### Interference of the Personal Self: Feelings of Failure

During 1994, my mistakes were a reflection of my poor motivation and half-hearted efforts. I was hoping that several lectures would improve things, but my initial approach lacked preparation, knowledge and enough time in which to develop a bond with the groups. I made very little effort to undertake any self-reflection about those difficulties at the time. However, as the process continued and my involvement became greater, the struggle began to resonate on a very personal level.

It was around the middle of 1995 that I began to feel depressed and apprehensive before every session. I see now that I failed to reflect on deeper levels and to bring out meanings spoken in between the lines, for example when the first group was talking about a party but mentioned, by the way, that it took place at the time when Mohammed died; or when V.H. spoke of his dream; or when Z.S. spoke of his brother's death. My avoidance strategy became apparent in either avoidance of comments on the process or changing the subject. After several sessions, I began to

notice that the thalassemia patients and parents often used death as a time orientation for different events. They would refer to a certain time as follows: "Remember that was just when R. died"; or: "You know that doctor left at the time when L.R. died." But I was scared to look at that. I did not dare ask more about how they felt about that death – I just left it. Or I would pick up on something else. I believe, however, that this avoidance strategy was my way of surviving the chaotic hospital system, the workload, and perhaps most of all, the personal difficulties I was experiencing. McDaniel et al. (1992) point out the importance of addressing the therapist's personal issues, such as tolerance for loss and uncertainty, a spiritual dimension in the therapist's life, dealing with issues of family of origin, and health beliefs in relation to the interactions between therapist and patient. In addition, they stress how important it is for professionals working with terminally ill patients to establish a support system. Leff and Walizer (1992) emphasise that these professionals may experience feelings of hopelessness, which may interfere with their ability to reach out compassionately to families in great need.

I coped by cutting out complexity or reducing it to simple frames with which I could cope more easily. Lal Sharma (1995) reports that therapists show decreased awareness of their own process when a patient's issues are emotionally charged for the therapist. This ultimately influences the course of the therapy, usually in a negative way. Throughout 1995, the therapy process with the thalasseemics went through different kinds of distractions – externalities such as chaos in the wards and, at times, unbearable noise from the renovations. Internal distractions came from either my own behaviour (such as my tense posture), or from prejudices and unresolved personal, emotional issues (Lendrum & Syme, 1992).

Failure stimulates further failure when the therapist has been unable to acknowledge that the failure lies in her belief in her own perfection (Kottler & Blau, 1989). Confronting our failures does not mean never making the mistake again, but it does mean making fewer errors. The inability to acknowledge and deal with failure, say Kottler and Blau (1989), stunts the therapist's growth, as she is unable to realise her weaknesses. Further inability to recognise failure would lead to the development of blind spots. Ultimately, it is the client who suffers as a result of the therapist's stagnation and her unresolved blind spots, and there is nothing more dangerous than

the wounded healer who thinks she is perfect. When the therapist feels fear in confronting certain feelings of her own, like sadness, anger, or anxiety, she may inadvertently repress the expression of such feelings in her client (Kottler & Blau, 1989).

When I began to see V.H. and the two older thalasseemics, Z.S. and M.P., conversations about death became inevitable. They mentioned it so many times that it became impossible to avoid it. It was around that time that I began to struggle with letting go of control. I began to feel tearful for no apparent reason. At other times I felt angry at the thalasseemics for making me feel all those feelings that were forcing me to take a step back and self-reflect. The need for a deeper understanding of my professional and personal selves, and of the connections between the two, created a need for self-analysis. Around the middle of 1995 I decided to start personal therapy. Kaslow and Friedman (1984) discuss the lack of agreement in the literature about whether personal therapy is a prerequisite for being a good therapist. They cite several studies which point to the professional benefits of personal therapy: experientially derived knowledge of what it is like to be a patient; a reduced tendency to develop undetected counter-transference problems; enhanced listening skills; increased cognitive flexibility; and more stable and elevated self-esteem. They conclude that the psychotherapist requires personal therapy as a way of promoting her or his personal identity and self-concept.

In 1995 I participated in a workshop on supervision organised by Rochester University. They looked, in particular, at the self of the supervisor in relation to the self of the supervisee. They discussed the family of origin and how it affects supervisors' position in supervision. The format and ideas from that workshop strongly reinforced my need to look at myself and my personal history in relation to my struggle with the thalasseemics.

After the workshop, a colleague and I decided to start a support group for supervisors and to continue with the work and the ideas we had started on and been exposed to at the workshop. At the beginning it was a big group, but over the years four of us formed a very close system, which was a substitute family that we called a "cuddle group" (Whitaker, 1989). The group diffused emotional intensity and created a safe space to explore how our personal histories affected our professional roles.

Anxiety and emotional blocks in clinical work are often traced back to unresolved processes in the therapist's family of origin (Titelman, 1987).

As I have indicated, my conversations with the thalasseemics were touching some sore spots. I found myself on the edge of crying after each session with them. At first I tried to control my emotions because of my professional belief in the necessity of remaining neutral. However, as the process developed it became impossible to eliminate my feelings (Steier, 1991a). Self-reflection opened up a space to look at the origins of my fear of my emotional self and of vulnerability (Garfield, 1987). This self-analysis subsequently also led to a deeper understanding and resolution of some of the issues that were negatively affecting my professional abilities. As Kaslow (1984) observes, pressure from therapeutic impasses encountered with one's own patients can serve as a motivating force to resolve repressed conflicts from childhood in self-analysis or in personal therapy. I felt that every bit of my professional and personal self was being challenged. Theories I used to follow seemed useless, and my "neutrality" and boundaries were becoming questionable. How could I stay neutral in the face of death? When I moved beyond the objective, neutral frame I felt I was on "less-than-certain territory" (Amundson et al., 1993, p. 115). Having no familiar guidelines to follow, I began to feel vulnerable and self-doubtful. I had always believed that a knowledge of theories and interventions was what made the "magic" happen, but I began to discover that therapy is all about relationships, and myself in relation to the other person's self. That was when the first-order and second-order cybernetics became relevant. I moved from the observer position and neutrality to become a participant in the therapeutic process. I was struck by the connection between my personal characteristics, such as the need for control and a tendency to take too much responsibility, and my choice of theoretical frames, which assured me of an expert position. In those days, I called myself a strategic therapist – one who employs strategic interventions to produce change in the therapeutic system. This is an instrumental approach which, by utilising the therapist's expertise and power to influence change, promotes the therapist's position of power (McNamee & Gergen, 1992).

I began to look at myself in relation to my family of origin and found, as Titelman (1987) maintains, that the problem of over-functioning and over-responsibility as well as difficulties in dealing with emotionally charged issues in clinical work can be traced back to unresolved processes in the therapist's family of origin. I faced the sudden realisation that the strength I was so proud of was achieved through denial. Everything painful was locked away in a box, but my conversations with the thalasseemics triggered some of the forgotten feelings. The work of defining self in relation to one's own family of origin is based on understanding one's own position in the family's emotional system (Bowen, 1978). In 1995 I began the process of acquiring this understanding when I decided that it was time to open the secret box of stories about my family of origin and my personal history.

## CHAPTER 5

### CYBERNETICS OF PERSONAL HISTORY

From a constructivist perspective, we understand the world through interactions in which reality is created through multiple meanings. Consequently, what we know is always the construction of the observer (von Foerster, 1984). The constructivist position means being aware of our own epistemology (Hoffman, 1992). The therapist's self-reflective process is intrinsic to her understanding of her own epistemology. Our ability to understand multiple realities, which are created in interactions, is enhanced by the inclusion of a wider context. In order for you (the reader) to understand how I construct my view, we need to look at my past and present life stories, which have created a unique context for my subjective reality.

The participatory position involved in second-order cybernetics implies that the therapist is not a passive observer but an active participant in the construction of multiple meanings. Thus while we understand that there is no objective knowledge, the therapist should be aware of her own biases and prejudices in constructing her reality.

In systems theory it makes no sense to analyse any person independently of the wider context. Instead of studying objects or people discretely, we study them in relationship to each other. The focus shifts from isolated monads to relationships between the parts of the system (Becvar & Becvar, 1996). The first system we know – the one we are born into – is the family system, but the family system is a component of a larger system such as a culture or country. From a systemic perspective, our view of reality is dependent upon and mutually constructed within the context of our environment.

#### Country of My Birth: Yugoslavia

I was born in 1962 in Belgrade, the capital city of Yugoslavia as it then existed and of the present, but much smaller, Yugoslavia. At that time, Yugoslavia consisted of six republics: Serbia, Croatia, Slovenia, Bosnia and Hercegovina, Macedonia and Montenegro, and two autonomous republics, Vojvodina and Kosovo.

The union between Croats, Serbs and Slovenes took place in 1918. Even at that time there were fundamental differences in approach – the idea of a federal state, supported by the Croats and Slovenes, being opposed by Serbia's preference for a highly centralised state. In 1921 the Serbian parties made an alliance with the Muslim parties, resulting in a centralised state that was greeted with growing bitterness on the part of the Croats and Slovenians. In 1929 the Serbian King Alexander, frustrated by the inability of the politicians to make progress in resolving the disputes between the different groups, dissolved the parliament and declared a personal dictatorship. The name of the country was changed from the Kingdom of the Serbs, Croats and Slovenes to Yugoslavia. In 1934 King Alexander was assassinated by a Croatian terrorist organisation. Prince Pavle was installed as Regent, and in 1939 he made provision for a partially self-governing Croatian republic. In 1941 Yugoslavia was invaded by Hitler, and Regent and government fled the country.

As a response to German occupation one group set up a resistance movement loyal to the king and monarchy, while another group supported the communist partisans and their leader, Tito. During the occupation Serbia sided with the Alliance, while Slovenia, Croatia and Bosnia sided with Germany and Italy. Historians are not in dispute that the mass murder of Serbs, Jews and gypsies took place in Croatian concentration camps. However, there is dispute about the number of people executed. Calculations vary from 30 000 to 700 000 depending on which side is arguing the point. Unfortunately, most of the documents from the concentration camps were destroyed by the Croats, and very few inmates survived to tell the story. This piece of history was to become yet another of the many issues that spread hatred and subsequently led to a final military conflict between the two republics in 1991.

After liberation in 1945 by the Red Army and the Western Allies, these republics once again merged with those of Yugoslavia. A federation of six republics replaced the monarchy, and the Communist Party seized power. The final roundup of monarchy supporters was completed in the early 1950s, when most of them were executed for treason.

After World War II and the establishment of communism, religion was forced out by the establishment of the new “religion” called communism. Previous to this change, the northern republics of Yugoslavia, Slovenia and Croatia were Catholic, Bosnia was Muslim, while the southern republics of Serbia, Montenegro and Macedonia were Serbian Orthodox. However, after 1945 religion was seen as supporting old structures in society and was banned from the official scene.

In the sixties and seventies Yugoslavia held a very special position in Europe. It was in the eastern region of Europe and had a communist regime, but was very different from the rest of the communist countries in the eastern bloc. This special position resulted from President Tito’s decision, in 1948, to break with Russian and Stalinist politics. Literally overnight, thousands of people who supported Stalin became traitors and landed up in a labour camp on a deserted island called Goli Otok.

The good consequence of that break was the opening up of Yugoslavia to the west. In the 1950s and 1960s, economic reforms brought prosperity and Yugoslavia emerged as a major international tourist destination. Unlike our eastern neighbours, we were free to travel anywhere in Europe, and could also afford it. This was one of the reasons that Yugoslavs felt superior to the other eastern European communist countries, whose citizens were forced to stay at home. At that time, Yugoslavia was well off and millions of Yugoslavs went abroad to spend their money. Those were the times we all remember as the good times.

For most of my childhood years I saw Tito as synonymous with Yugoslavia. He was our beloved president, whose life and thoughts were cherished and idealised throughout my school years. Our history books made very little reference to the time before Tito or to World War II. It was only after his death in 1980, when nationalistic feelings were beginning to develop, that people in Serbia suddenly started talking of the Serbian Kingdom and its proud past, and I realised that we had a history before Tito. After Tito’s death there was an upsurge of long-suppressed nationalistic feeling, not just in Serbia but in all the republics. This subsequently led to a nationalistic mass hysteria, which destroyed every sign of past unity. Banjac’s (2000, on-line) analysis of the collapse of the state following Tito’s death is illuminating:

The irony of his death, which occurred in 1980, is that he created the conditions for the eventual destruction of his life-long effort. Instead of allowing the process of democratisation to establish its own limits, he constantly upset the work of reforms while failing to satisfy adversaries. He created a federal state, yet he constantly fretted over the pitfalls of decentralisation. He knew that the Serbs, Croats and Slovenes, and others could not be integrated within some new supranation, nor would willingly accept the hegemony of any of their number; yet his supranational Yugoslavism frequently smacked of unitarism. He promoted self-management but never gave up on the party's monopoly of power. He permitted broad freedoms in science, art, and culture that were unheard of in the Soviet block, but he kept excoriating the West. He preached peaceful coexistence but built an army that, in 1991, delivered the coup de grace to the dying Yugoslav State. At his death, the state treasury was empty and political opportunists unchecked. He died too late for constructive change, too early to prevent chaos.

Thus beneath this growth were certain fundamental weaknesses and problems that finally brought the country to its knees in 1991. Most seriously, the country's prosperity was not uniform, and existed despite deep-rooted economic, cultural and religious differences between the northern republics of Slovenia and Croatia and the southern republics of Serbia and Bosnia and Hercegovina. An attempt to resolve the economic disparities was made by Serbia, which initiated and led a redistribution process. Unfortunately, this created a perception of Serbia as abusing federal power to curtail republican autonomy.

But perhaps we need to look a little further into the past in order to understand the reasons for the 1991 civil war.

Between 1970 and 1980, several constitutional reforms shifted the power in the direction of the republics at the expense of the federation. As a result, Slovenia and Croatia were steadily drawing away from the others. Tensions arose, with the responses from every republic growing progressively more nationalistic, a situation which, in Serbia, was skilfully manipulated by Slobodan Milosevic. He rose to power in 1986 on becoming president of the Communist Party, and in 1990 initiated constitutional reforms that abolished the autonomy of the Serbian provinces. His reluctance to establish a multiparty system at a time when the federation was in great need of re-legitimisation resulted in attempted secessions on the part of Croatia and Slovenia. A ten-day war between the Yugoslav Army and the Slovenia militia and

civilian reserves resulted in Slovenia's secession, but as very few Serbs lived in Slovenia, the Yugoslav Army withdrew. Croatia and Bosnia were, however, very different issues, as Serbs constituted around 12% and 31% of their respective populations. A bitter and protracted civil war set in, characterised by the use of irregular troops, "ethnic cleansing" and the creation of more than three million refugees.

By the end of 1991, it was clear that the old Yugoslav federation had collapsed and a new Federal Republic of Yugoslavia, comprising Serbia and Montenegro only, was launched in 1992. Yugoslavia's effort to keep the federation intact by force was punished by the imposition of heavy economic and cultural sanctions by the European Community. In 1996 the withdrawal of Serbia's military support for the Croatian and Bosnian Serbs was rewarded by the lifting of sanctions.

However, sanctions were reinstated in 1998 when Albanians in the Serbian province of Kosovo attempted to secede from Yugoslavia, and Serbia responded by sending in military and paramilitary units. After several months of negotiation with the Milosevic regime, NATO took an aggressive approach, and for the first time in its history, engaged in a military attack against an independent country – Yugoslavia. After a month and a half, Milosevic's troops withdrew from Kosovo, and NATO troops entered the territory. Life in the Yugoslavia of today looks very different from the picture of the prosperous sixties: its economy is destroyed, the black market thrives, racketeering is rampant and politicians and criminals work hand in hand.

When I immigrated to South Africa in 1992, the whole situation in Yugoslavia was so upsetting that I needed to go as far as possible from the horror of what my country had become. South Africa, being on another continent, seemed far enough away. It was a blessing that so few people knew about the situation back in Yugoslavia, and as most were confused as to who was who, I felt no pressure to describe or defend anyone's side. I felt ashamed of my own country and angry about the loss of an important part of my identity. However, as a result of my work with the thalassemia families, the issue of loss reappeared. When I recall previous situations of loss, I can see that I used the coping pattern established in my family in this instance as in every other – cut-off and denial.

Emigration is always connected with a loss of meaning as a result of being uprooted (Marris, 1980), which awakens a sense of loss (Shamai, 1998). I became overwhelmed with pictures from the past. Pictures of Belgrade, my town; Jove Ilica, the street behind my house; walking back from school with my friends; the corner where we sat and talked endlessly; the park and the bench where my first boyfriend kissed me; Knez Mihajlova street, where we used to gather during my student years; sitting at local coffee shops, listening to street musicians ... Suddenly I would miss every beat of my town. These pictures made me want to cry. It was then that I began to mourn the loss of my country and the loss of a national identity.

I was brought up as a Yugoslavian, and was proud of it for 30 years of my life, and when my country fell apart I felt that a big part of my identity had been stolen from me. I did not and even now do not understand the complexity of reasons for the split and the violence that erupted. In Serbia, people suddenly remembered cousins and other family members who had been killed during World War II by the Croats in their concentration camps. The Serbian press reinforced the nationalistic feelings by publishing stories that demonised Croats in general. Evidently the pain of the past had never been forgotten, even though for so many years it seemed that there had been reconciliation. In 1998, my mother's goddaughter was hit by a NATO bomb. I cannot even begin to understand the horror her family went through, burying the pieces of their 28-year-old daughter, her head missing. The air attack had no negative effects on Milosevic's dictatorship, and in fact it united the Serbs against the outside enemy – all NATO countries.

In my life, the most profound consequence of the civil war was emigrating and starting a new identity in South Africa. The loss of our house at the Croatian coast in 1991 and, more important, the loss of relationships that had been such a vital part of my life, was another point of grief and anger. My grandfather had built a house at the Croatian coast in 1963, which I always considered my other home. My best memories are about times at the coast and friends that I knew from childhood. It confused me terribly to think of them as enemies, but officially that was the case as I come from Serbia and they are from Croatia.

It was like *déjà vu* – that same pull that I felt long ago, between my loyalties to my mother and my father, when overnight my father became the enemy. Now it

was between my Serbian and my Croatian side. Any attempt I made to say anything positive about the Croatians, or to defend the Croatian side in conversations with other people, was considered treason. I could not see any amicable way of resolving the issue of loyalties by siding with either of the two, so I left.

The issue of split loyalties and my difficulty in making sense of them has followed me throughout my personal life. However, in my professional work it is often possible to facilitate the process when all sides get together and discuss the relevant issues and the outcomes that are necessary for healing the wounds. I wish that a similar process had happened in my ex-country, instead of the blood and the refugees all over the world.

### My Family of Origin

There is no way for human beings to relate to each other outside of a context of subjectivity. The level of subjectivity is proportional to the level of maturity and the level of resolution of past and present anxieties for each individual. Building knowledge about oneself and one's family of origin is important for everyone, but even more so in the life of a therapist. Regardless of the therapist's theoretical approach, subjectivity will interfere with the therapeutic process with greater or lesser intensity, depending on the therapist's awareness of her own issues.

The experience of emerging out of one's own family is a very different process to that of developing knowledge that may create a better understanding of one's family. According to the theory developed by Bowen (1978), the process of differentiation is the basis for human behaviour. This concept describes the two pulls – togetherness-sameness-belonging and the opposing pull of individuation-separateness (Meyer, 1987). For those whose togetherness pulls outweigh the pull of individuation, every decision will need the approval of others, and the simplest task then becomes an effort to please everyone – the task most unlikely to be ever achieved. For those whose pulls of separation outweigh those of belonging, life may be no less complicated but it is at least likely to be less arduous (Meyer, 1987).

For the therapist, knowledge of differentiation is critical for understanding human nature and minimising the impact of his or her reactivity in therapeutic

situations. However, knowledge of differentiation and understanding of human emotionality alone do not mean that the therapist will necessarily develop excellence (Meyer, 1987). The actual process of differentiation leads to developing one's real self in the family of origin, which requires a balance between gathering the family history and defining one's position with respect to the important issues. The knowledge of family history and functioning must be balanced by knowledge about the self in relation to the family.

Titelman (1987) states that therapists are likely to function more effectively in their clinical practice if they face toxic issues in their own families. According to him, working on one's own family provides the avenue for lessening one's tendencies to become over-involved with clinical families and avoiding the emotional "burn-out" syndrome. Over-involvement with client families would parallel under-involvement with the therapist's own family. He concludes that enhanced functioning in one's own family can improve not just the therapist's personal functioning but also his or her professional functioning.

When in 1995 I began my self-reflexive process, my understanding of my position in my family was not only limited but self-deceptive as well. My efforts to understand this position came after years of minimal contact with my family (Meyer, 1987). In addition, I had some information about my maternal family but very little about the paternal side.

I could find the courage to open up that process only when my need to re-connect became stronger than my level of anxiety (Meyer, 1987). The courage to acknowledge my need for connection with my family was born through listening to the pain and sorrow of the thalassemia families losing their loved ones. As I started my journey back to my family of origin I began to see how important it was to consider my own position within that context.

The first question I asked myself was whether I had some special position, whether I had received more than a predictable amount of the family's emotionality, positive or negative (Meyer, 1987).

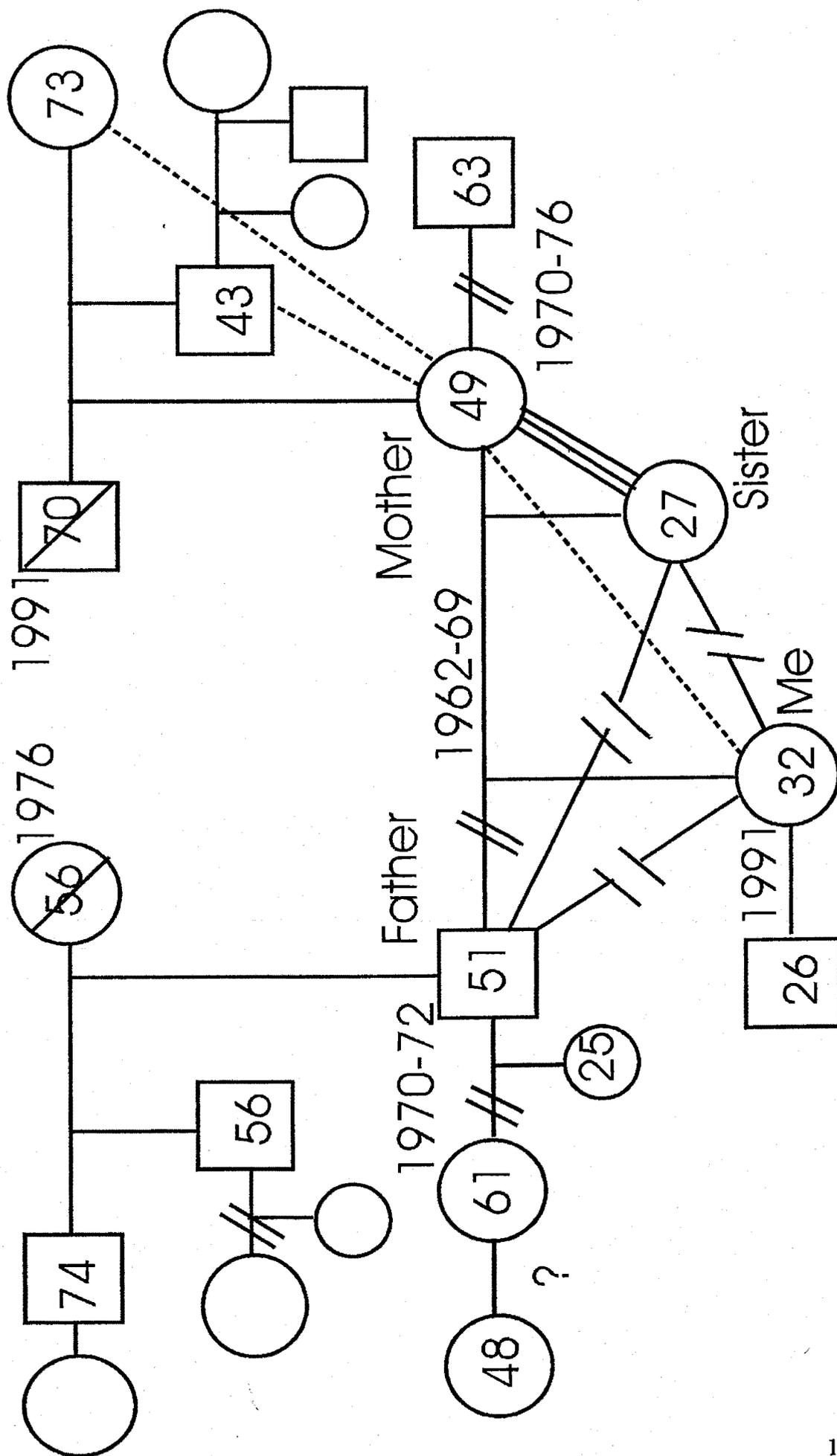


Figure 5.1 Genogram: 1994

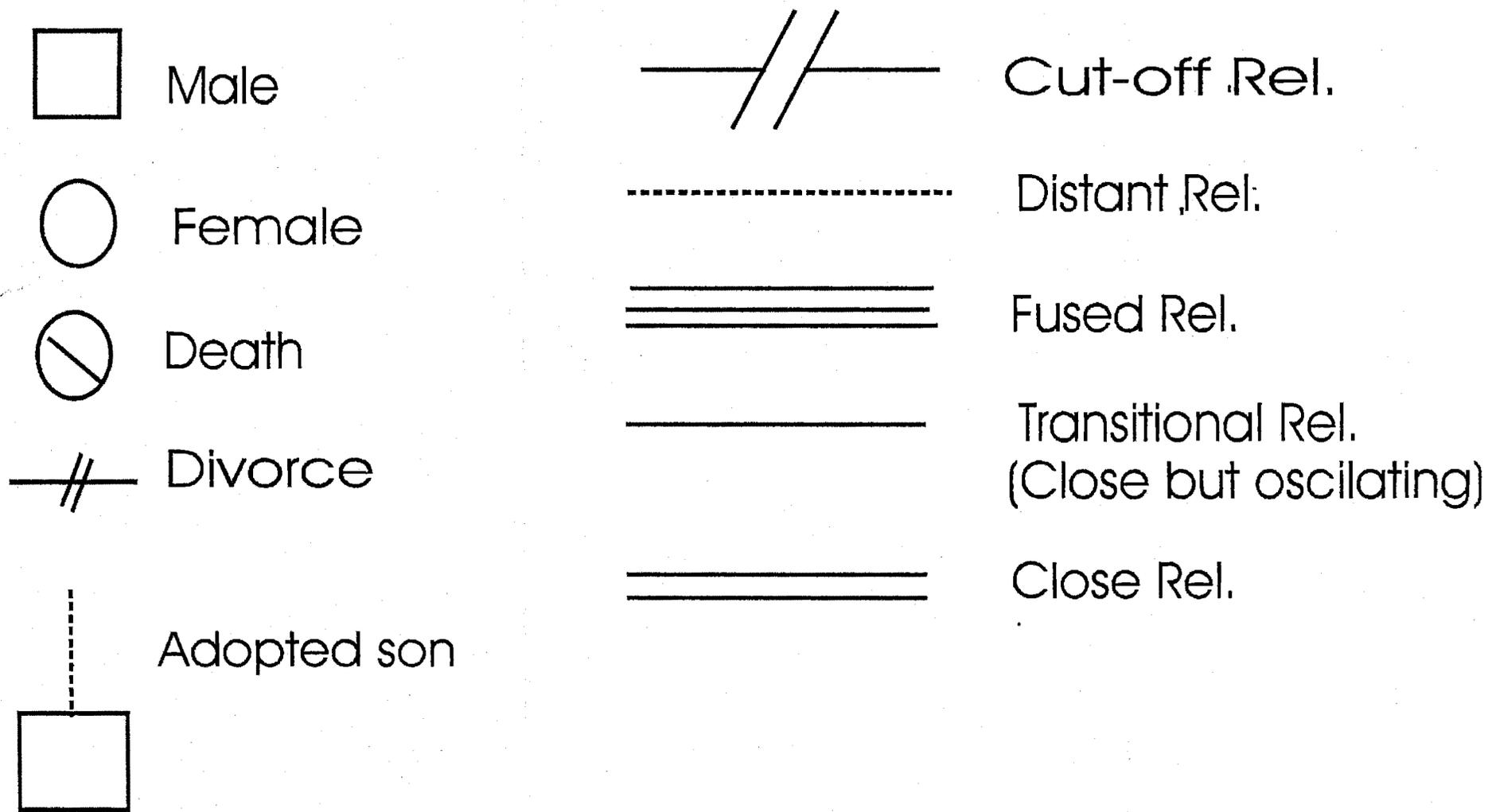


Figure 5.2 Genogram legend

## *The Story of the Stone*

“You are like a stone.” This metaphor had at least two meanings: “You are hard”; and “You are the stone to lean on, strong and supportive.” I think that both terms reflect the way my family perceived me for many years. Several years ago I sent my mother the following letter:

Once upon a time there was a stone. It lived in the middle of nowhere. But at that time the stone could not really feel (can a stone feel anyway?). But as it had lived in isolation for so long, it had no knowledge of any other way. So the stone had no other concept to measure up to, and being isolated felt fine.

But at one time the wind was very strong and it brought some funny-looking seeds the stone had never seen before, that soon grew into nice green grass. The stone watched the grass grow and became very attached to it. This was quite a sudden feeling, not like anything the stone had felt before. Then the stone began to compare what it was like being so isolated in the middle of nowhere, and what it was like with the green grass around it. The isolation did not look so desirable anymore. A feeling of loneliness suddenly overwhelmed the stone. And the stone began to cry ... And the more it cried the more it felt sad, and the more it cried ... At first the tears made a little pool, but after a few days, as the stone could not stop crying, the pool became a lake and then a river.

Across the seven hills and seven valleys it was a time of drought, and when the animals heard of the green grass and beautiful river on the other side, they decided to migrate. The stone was busy crying when it saw a huge number and variety of creatures appearing. It had never seen such beauty, and it was so impressed that it forgot its sorrow and stopped crying. Years later, the stone could not even remember how lonely it had felt some time ago. Now the stone is surrounded by gracious animals and the days are full of playing and laughing. Life has never seemed more contented.

At the time my mother made no comment on this letter and when, after a year, I finally questioned her, she denied ever getting it. When I described the content she then remembered it, but avoided further conversation by saying that it was not something she could discuss over the phone.

This process describes well how my family deals with anything provocative.

*A Tree with Unhealthy Roots is an Unhealthy Tree*

As Titelman (1987) observes, work with the family of origin involves a life-long commitment. He compares the family to a tree, where the strength of the family depends on the healthiness of its roots. If the roots are rich, the tree will grow rich and healthy; but if the roots are cut, the growth and health of the tree will be affected. The same applies to the family.

Going back to the time of my birth, I am always painfully aware that it was with my conception and birth that many things went wrong. The first thing was that my mother was just 16 at the time, and my father 2 years older. The second thing was the differences between my parent's families. My mother came from a family that was considered "bourgeois" by the communist government, which in the 1950s had taken all its land and properties through forced nationalisation. My father, on the other hand, came from a family that had very strong links with the communist government. Just these two factors were enough for a disaster. The two families never saw eye to eye.



*Figure 5.3* My parents' wedding (from left to right: paternal grandfather, mother, father, maternal grandfather and paternal grandmother).

Two days of talking and arguing between my mother and her parents ended with them granting her permission to get married. As she was already pregnant, I was

born only 7 months after the wedding, something I discovered many years later. A few months after the wedding, it was clear that it had been a huge mistake, but it was too late. Living with my mother's parents for 4 years made things worse, as the hatred between them and my father was instant and life-long. My mother told me that I was a premature, colicky baby who cried all the time. According to her, my father had a very violent temper that was often provoked by my crying. My grandfather would apparently try to protect me, which led to violent arguments between him and my father.



*Figure 5.4* With my maternal grandparents at the age of two.

My sister was born 4 years into the marriage, and at that point my grandparents moved out. A year later my mother found out about my father's numerous affairs and filed for divorce. He tried to change her mind, promised anything and everything, begged, even attempted suicide, but nothing changed her mind.

At the level of the nuclear family, Titelman (1987) describes the differentiation of the self in terms of "the way family members are emotionally stuck together". He maintains that the level of differentiation of an individual is determined by a constant interplay of several variables, as follows:

1. differentiation level in the parents at the time of a child's birth
2. sex of the individual and how this fits into the family plan

3. individual's sibling position
4. normality of the individual's genetic composition
5. emotional climate in relation to each of the parents before and after the birth of the individual
6. quality of the relationship of each parent with their parental families
7. number of reality problems in the parents' lives before and after the birth of the individual
8. parents' ability to cope with the emotional and reality problems
9. general level of differentiation in each parent as determined by the context into which they were born
10. differentiation level of each grandparent. (p. 16)

When I applied the above variables to my family of origin I saw the following:

1. My parents were very young and immature, and certainly far from differentiating from their parents. My father was terrified of his father, to such an extent that when he needed to speak to his father he would ask my mother to do it instead. On the other hand, my father showed enormous anger and resentment towards my mother's father, which may have been a projection of the feelings for his father that he was never able to express. My mother had never openly challenged her parents – but then my father did that task for her, and she could stay “innocent” in the eyes of her parents.

2. The fact that I was a girl was a huge issue for my father. He was born in Montenegro, where having a son had always been a priority, so much so that, in the old days, a man could leave his wife if she did not give him a son. Perhaps his desire for a son was partly why I was such a tomboy. I never played with dolls and I was very keen on sporty games that most girls found too rough. Even my emotional “hardness” may have something to do with social expectations of boys. Some might also consider my focus on a career instead of a family, and my assertive communication skills, as inappropriate for a girl.

3. My position as firstborn meant that I was the older sibling. The responsibility issue entered my life most seriously when I was 6 years old and my sister a year old. This was when my parents got divorced and my mother became a single mother. For me, this meant caring for my younger sister, cleaning the house and behaving responsibly at school. I have no memories of that time, but I assume that my mother

was depressed and I felt a need to make her life easier by doing my duties as perfectly as I could. At times, my mother gave vent to violent outbursts about any kind of irresponsible behaviour. Being irresponsible and stubborn meant being imperfect. She showed no tolerance for these characteristics, which she associated with my father and which made her furious. So I tried hard not to remind her of my father by being very serious and responsible. I became emotionally hard and I never cried. Sometimes, when my mother was upset with me and gave me hidings, she expected me to cry as a way of showing that I was sorry. She saw my lack of tears as a challenge to her authority, and would lose control and become physically abusive. Perhaps her anger was about herself. Maybe she could not forgive herself for the failure of her marriage and the enormous disappointment she had been to her parents. Her high expectations in relation to my school achievements, general behaviour and home duties taught me that only the best is acceptable. I learnt no tolerance for weakness, vulnerability or imperfection, which is probably best reflected in my story of the stone and family comments that I was “like a stone”.

In a study by Racusin et al. (1981) it was reported that psychotherapists described their primary role in their family of origin as that of “caretaker”. This role may require a child to be the “strong one” who sets aside his or her own needs to serve others. This may create a pattern whereby the child is alienated and isolated from the nurturance that she or he so badly needs. Friedman’s research (1971) suggests that this process of internalisation of the caretaking role is the most important, and first, step towards entry into the profession of psychotherapy.

4. I am not quite sure how to measure the normality of the genes in my family, as some of the traits one should explore have been kept secret for years and there are maybe many more.

5. The emotional climate in relation to each of my parents, before and after my birth, closely relates to the circumstances previously described. These are: my mother being under age and pregnant; differences in social background; the fact that all the sacrifices turned out to be for a baby girl and not the expected baby boy; the fact that my maternal grandparents lived with my parents for 4 years of their marriage; and the hatred between my father and my grandparents. It is easy to see that the atmosphere could have been only aggressive, tense and unhappy.

6. Before her marriage, my mother had a very compliant relationship with her parents and the only time she challenged them was when she fell pregnant and married my father. She had an enmeshed relationship with her father, who ran her life before, during and after marriage. My grandfather's tendency to take over and dictate was the main reason for the arguments and occasional violence between him and my father. My mother had a distant relationship with her mother who, she believed, never forgave her for being sexually active so early, getting pregnant, marrying someone her mother detested so much, and then getting divorced at a time when divorce meant embarrassment for the whole family.

7. There were numerous problems my parents tried to cope with in their daily reality. Some were related to the above dynamics and some were the result of being so young. My mother managed to complete her matriculation examinations, but instead of studying further she looked for work as she had a family to look after. During their 6 years of marriage, she was alone for a year while my father served in the army.

8. As I know so few stories from that time, my knowledge of my parents' emotional coping is limited. However, I assume they did not cope well. Judging from the stories about my father's violent outbursts, his coping mechanisms were very poor. My mother probably coped by keeping quiet, which she learnt from her mother. She managed, somehow, to deal with his abusive behaviour, but his affairs she perceived as the ultimate betrayal.

9. My parents' general level of differentiation in relation to their positions in the family at the time of their birth is a complex and to me, still, a largely unknown variable. I can only guess what was happening in the two families at the time. I know that my mother was born just after World War II, which for many families was a good time, but possibly not for hers. Those were the years when the communist government came to power and took all my maternal grandfather's properties through forced nationalisation. On the other hand, it could be that it was exactly the opposite for my father's family, as his father rose to a high position in the communist party.

10. To comment on the differentiation level of the grandparents is even more difficult, as I have a limited knowledge about their families of origin. My grandfather

left his family home when he was 12 and did not see his parents for several years. Throughout his life he kept them at a distance. My grandmother seemed closer to her father than to her mother, but at the age of 9 she was sent to boarding school and saw her parents only twice a year. My grandparents' emotional distance from their families of origin may perhaps explain their fusion with their children, which made it difficult for my mother to separate from her parents. I know nothing about the families and childhoods of my paternal grandparents.

*The New and the Old Relationships*



*Figure 5.5* At the age of four and a half with my mother and maternal grandmother and my few-months old sister.

I was 5 years old when my parents separated and 6 when they got divorced. When my mother discovered that my father had had several affairs, she asked him to leave. However, my father refused to move out of the house, and for a year he remained in a room with a separate entrance but a shared bathroom. This situation apparently provoked numerous arguments, as my mother would get extremely upset at finding another woman using her bathroom. My parents continued their bitter relationship through years of ugly court battles for maintenance. By then, my father had already met his next wife and a few months after his divorce he remarried. His second wife was a divorcee, 10 years older than he and with a daughter from a first

marriage. A year later they had a daughter – another major disappointment to my father, who had again hoped for a son.



*Figure 5.6* At school, at the age of six and a half.

When I was about 9, and 2 years after the birth of his third daughter, he divorced his second wife and immigrated to Germany. There he married his third wife, a woman of German origin, a divorcee with a daughter from a first marriage.

Two years after the divorce, my mother introduced her second “husband” (whom she never actually married) to us. He was a policeman, 14 years older than her, divorced, with a son who lived with his mother. We never liked him. He seemed to love our mother, but would have preferred having her all to himself. His cold, strict approach to discipline led to numerous arguments, and when I was 14 he moved out. For a long time I believed that I was responsible for their break-up, because my mother told me that she had left him because he and I did not get along. I felt very guilty and responsible, and it is only in the past few years that I have started to think that after divorcing her first, abusive, irresponsible husband my mother

needed an older, responsible man who could look after her. Judging by her behaviour after they separated, I think that she became bored with his seriousness and detachment, I have also come to realise that for most of her life, my mother had trouble taking responsibility for her own failures. She kept denying her own failures and blaming everyone else. It was not without defensiveness and uneasy feelings that, in the past few years, I confronted the similarity of the process in my own relationships to that of my mother.



*Figure 5.7* At the age of fourteen with my mother, stepfather and younger sister.

After my stepfather moved out, my mother entered her fun time. She went out, drank, changed boyfriends, and basically tried to catch up on the fun she had not had when she should. My grandparents knew nothing of this, as my mother asked us to keep it secret from them. She never married again or had a serious relationship.

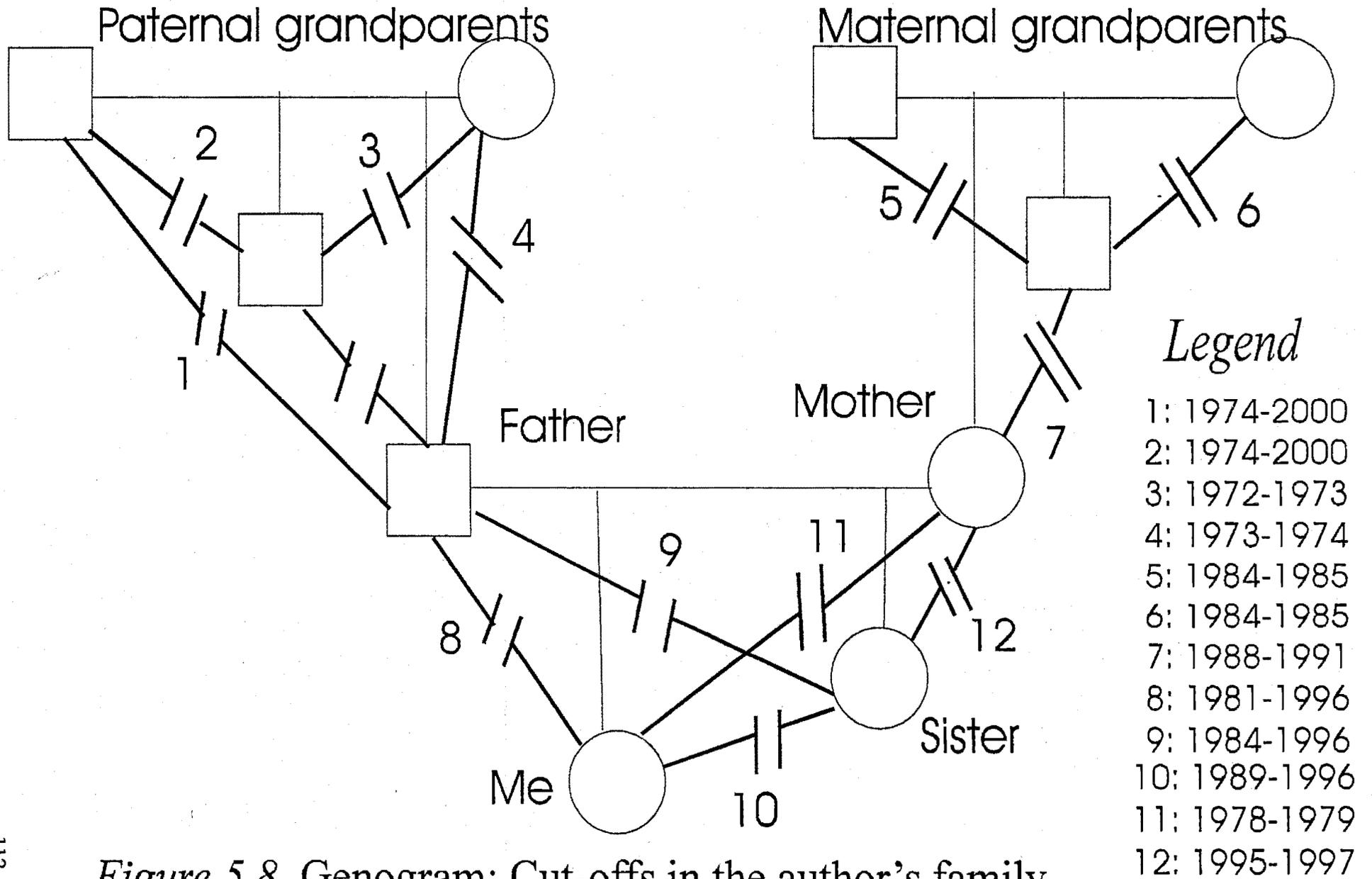


Figure 5.8 Genogram: Cut-offs in the author's family

### *More on Cut-offs and Triangulation*

During my adolescence, my relationship with my mother followed two extreme patterns. We were either fused, in which case I played the role of her friend and she would confide in me, or I would I try to differentiate and do something she did not approve of, in which case we had major conflicts. When I was 16, after one of our many violent arguments, I moved out of the house for a year. Bowen (1978) says that emotional cut-off refers to the phenomenon of emotional distancing in the form of an internal mechanism or physical distance. Emotional cut-off is at one of the poles of the separateness-connectedness continuum; at the other pole is fusion. Bowen also comments that those who experience intense cut-offs will be likely to seek close, dependent relationships that will provide an antidote to the cut-off. Because I was a minor, the social services got involved and brought me back home after a year. At that time our relationship was so damaged that we could not bear living together, so the house was split into two parts occupied separately by my mother and me. By then I was 18 years old and my sister, then 13, voted to move in with me.

At a time of stress, two people tend to draw in a third person, stabilising the system by forming a coalition, the two joining together in relation to the third. The basic unit of an emotional system thus tends to be a triangle (McGoldrick & Gerson, 1985). During my childhood and adolescence, when there were arguments, my sister and I usually joined “against” our mother. She would get her father (my grandfather) into an alliance with her, which created major difficulties in my relationship with him. When I did not talk to my mother for a year, I did not talk to him either.

The alliances changed dramatically when I was 27, and my sister and I had an argument followed by a cut-off lasting 10 years. At the time that I emigrated from Yugoslavia, my sister and my mother were very close while I was an outsider.

In respect of my relationship with my sister, I always viewed it through rose-tinted glasses, but 2 years ago I heard my sister’s version and realised how self-deceptive my view had been. Our relationship followed a similar pattern to the relations between my mother and myself. A progressive deterioration began when she entered adolescence, culminating in the major conflict and cut-off. After that I

moved out of the house and rented a flat with my boyfriend. My efforts to reconnect were unsuccessful and the silence between us remained unbroken for the next 10 years.

In June 1991 I got married in Vienna, without any of my family present, on the way to Holland where my husband and I were planning to settle. However, we had too little money and no luck in finding jobs, and after a month we returned to Yugoslavia. Two weeks later the civil war broke out. In the middle of 1992, while war was raging through the country, we decided to try our luck in South Africa. We were beset by anxiety and fear: we had no knowledge of the situation at the border and of whether they would let us leave. We had forged papers for a business trip on behalf of my mother's company, and we each carried a small suitcase to avoid looking suspicious. But we were lucky, and after 2 weeks of waiting for visas in Vienna, we arrived on the African continent in June 1992.

As regards my relationship with my father, I have no memory whatsoever of him during the time of my parents' marriage. According to my family, he was physically abusive and I was terrified of him. As to the times I do remember, I always felt as if I were an object. I would do anything my father ordered, and I was quite unable to oppose him or even voice my opinion. I also remember feeling totally overwhelmed by fear and anxiety in his presence. After the divorce my father did not keep up the relationship with my sister or me, and left it to us to maintain contact. I tried hard to keep the relationship going, but every time we saw each other I felt myself sliding back into becoming "the object". Unable to deal with that feeling, I finally decided to stop trying after another of the many painful incidents between us.

After their divorce and the years of bitter court battles for maintenance, my mother's hatred of my father was greater than ever. She disapproved of my visits to him, which were rare enough, and after he emigrated were minimal. For me it was an issue of loyalty to my mother, and I remained loyal, but with growing resentment. My mother's derogatory comments about my father throughout my adolescence often led to arguments, in which I felt the need to protect my father as he was never there to defend himself. In my fight to protect him from my mother, I somehow forgot the real truth about our relationship – which was that every time I saw him it left emotional scars. I can see now that he was damaged by his family, and probably

has no chance to recover in the time left to him. I am still trying to discover more about his family in the hope that it will bring more understanding, and forgiveness for all that happened.

For me, the family always meant my mother, my sister, and my maternal grandparents. I often felt isolated in my own family, especially in adolescence when I had no contact with any members of my family for a year. A considerable number of psychotherapists seem to come from families in which they experienced isolation and loneliness in their adolescent years (Guy, 1987). This may well prompt some people to enter the profession in the hope of finding closeness and intimacy while remaining in a somewhat invulnerable position. Perhaps the need that is potentially the most dangerous is the need to control and convert, which can often result from a sense of personal impotence in the therapist's private life (Guy, 1987).

We never visited any extended family, and as I grew up in that way I did not realise that things are very different in other families. My mother had a very distant relationship with her brother, and after an argument their cut-off went on for 5 years. After my parents divorced, my father's side of the family became "the enemy", so we had nothing to do with them. My maternal grandmother had only one sister, with whom she kept up a very distant relationship. My grandfather did not speak to most of his siblings as a result of their inheritance having been unfairly divided.

In Yugoslavia, as is the case among her southern neighbours, Italy and Greece, family always meant an extremely close, extended family, with several generations living together under one roof. When I began my journey back to my family, I realised the loss I suffered as a result of such distant family relationships and so many cut-offs. When other people talk of uncles, aunts and cousins, it has no emotional meaning for me.

### *The Philosophies of the Ostrich and the Lion*

I know some stories about my maternal grandmother's family, but it is very unlikely that she would ever tell anybody about the real issues in her family. Her belief followed her mother's, which was that bad things stay within one's self. In that way, my granny reminds me of an ostrich with its head deep in the sand, refusing to

see what is going on in front of it. The capacity for denial is so strong in my family that I have come to the conclusion that this protection mechanism may be partly genetic. So, in my granny's stories, everything is perfect and there is always a happy ending.

My maternal grandmother was born of the marriage between her Austro-Hungarian Catholic mother and Serbian Orthodox father. Religion was apparently not an issue and the family celebrated both Catholic and Orthodox religious holidays. Her father was a very temperamental man and what they called a "*bon vivant*", which meant that he loved fun, drinking and women. I have a suspicion that he was in fact a womaniser and an alcoholic – certainly, every family photograph pictures him with a glass and a cigar in his hand. My granny denies both, but her anxiety about alcohol problems when any of us has a glass of wine proves different. Her father died of a stroke during World War II at the age of 58.

My granny described her mother as having a typically Austro-Hungarian temperament, which meant she was a very reserved and emotionally distant person who never showed her feelings. She outlived her husband by 20 years. The other suspicion I drew from the family photographs is that her mother had depressive tendencies; my granny, of course, denies such suggestions, too. My granny is much like her mother, distant and never openly emotional, and she repeated her mother's pattern by marrying a man similar to her father: temperamental and liked by women. My granny got married a few months after her father's funeral, in the middle of World War II. Few men were available then because of the war, and her mother married her off to the first man who asked for her hand. I suspect that my grandfather had numerous affairs, but kept them "invisible". My grandmother's people looked down on my grandfather's family as being of lower class and less well educated. Similar patterns can be traced in my mother's marriage and mine.

My grandmother grew up under the strong influence of her mother's Catholic background, and at 10 she was sent to a boarding school, a French Catholic Girls' School, where she spent the next 8 years. She saw her parents only twice a year, during school holidays. In one of my conversations with my mother I heard about the emotional side of this departure. Apparently she was sent to boarding school without any warning, and with no information about the school. When she saw her parents 6

months later, she was shocked to see her mother with a “stomach up to her teeth” clearly close to giving birth after a pregnancy that had been kept secret for 8 months, until that moment. She was very upset by the news, and may have connected pregnancy and birth with being sent away and rejected by her parents. This story helped me understand some of my grandmother’s negative behaviour and comments about pregnancy and mothering.

The lack of a close relationship with her sister is possibly due to the 11-year age difference between them. The secrecy around her sister’s conception and birth, paralleled by my grandmother being sent to boarding school, did not make for strong bonding between the two sisters. Even today they are very distant, and in my whole life I have never even been to visit her sister.

If my granny is represented by the ostrich because of her inability to confront reality, then my grandfather is best represented by the lion, being proud, strong and stubborn. He came from a family of merchants. He was the last born of five children, three of whom were boys. He left his family home in a small town near the capital at the age of 12, following an argument with his parents. He went to Belgrade and joined his eldest brother, who owned a shop. The eldest brother was their father’s favourite and the other siblings resented him. Apparently after their father’s death, this son took all the money and refused to share it with the rest of the children, which resulted in a cut-off from the family. My grandfather and his other brother later had an argument that also led to a cut-off, and this brother died without their ever speaking to one another again.

Some years later, after the death of his older brother, my grandfather became a director of the business, which he represented in Germany for 8 years. He accumulated a good deal of wealth, which my mother invested well after his sudden death in 1991 of a stroke. She bought one of the family properties back from the government, which had forcibly nationalised it, and started her own business.

### *The Philosophy of Darkness*

When I think of my father’s family, the word “darkness” seems to be the most appropriate metaphor. First, I have so little knowledge about that side of my

family that it makes me feel as if I am in total darkness. Second, the few stories I have heard all reverberate with dark emotions: hatred, anger, violence.

After my parents became divorced, I was not allowed to visit my paternal grandparents. I still did so on occasion, but I kept it a secret from my mother, knowing that she would be upset. My paternal grandmother I remember as a soft-spoken, tall woman whom I think I liked.

My grandfather never spoke much, but he had a scary presence. My secret visits to my father's parents stopped after my mother found out about them and gave me a hiding. I was 7 at the time and my grandmother 41. She committed suicide 7 years later.

After my paternal grandmother's suicide there was a lot of guilt and blame between her husband and sons, each one accusing the other of being responsible for her death. As a result of these accusations, and disagreements around inheritance, my father never again spoke to his father, who died early this year (2000). My grandfather married a much younger woman exactly a year after his wife's suicide – another “bad deed” in a long line of so many that his sons never forgave him. My grandfather died without either of his two sons speaking a word to him again, and without acknowledging them in his will.

My father and his brother, when speaking of each other, seemed to have only hatred for one another from their childhood onward. My father was apparently his mother's favourite, and was the elder of the two sons. His brother was born with a birth defect that was corrected by the age of 9, after ten operations. According to my uncle, his parents used to be so embarrassed about this defect that they kept him inside the house until the last operation enabled him to walk. He never forgave his parents for this rejection, or his brother for being the “perfect one”. He and my father are entering approximately their twentieth year of not speaking to one another, and I imagine it will stay that way until they die.

### My Marriage

My family often made comments that implied that they did not expect me to marry. They gave two reasons for this belief: first, I was so strong-headed that “no

man could tolerate that”; and second, the amount of passion I invested in my profession left little space for a serious relationship. When I finally did get married, I decided to do it in a way that would create the least difficulties in respect of family. The thought of my family, with so many members not talking to each other, the anxiety of deciding what to do about having both my father and my sister at the wedding after such a long cut-off, all just seemed too much.



*Figure 5.9* My wedding.

The strange thing is that during the 2 years of living with my husband while he was still my boyfriend, things worked smoothly, but from the moment we got married the situation changed and the struggle began. It seemed as if, from the moment we married, conversations about divorce became a common theme. According to Bowen (1976, p. 79) it is “common for living together relationships to be harmonious, and for fusion symptoms to develop when they finally get married. It is as if the fusion does not develop as long as they still have an option to terminate the relationship.” It took several years before we stopped the practice of bringing divorce into disagreements, and to be honest, I was the one who seemed to bring up the “divorce issue” most often. It is the same as the pattern in my family, where any serious disagreement leads to a cut-off. I did not learn how to disagree with someone yet continue with the relationship, because disagreement was translated into rejection of one’s self, and perceived as a massive threat. In my marriage, I was the one who

persisted and rarely adapted, while my husband is the adaptable one with the ability to give way and apologise when he is wrong.

My husband is the younger sibling with a sister 4 years older than he. As the younger one, and the only boy, he was treated with special attention. His relationship with his father was a difficult but distant one. His father used to give him speeches about taking responsibility and being honest, which he felt were pushed down his throat. He was lucky to survive an accident at 4, but this event aroused his mother's life-long anxiety about his well-being.

Education in my husband's family was important for the sole purpose of getting a job and keeping it for as long as possible. Hoping for and working towards something bigger was not expected. As a result he never dared to dream or take risks, and he accepted that he would complete his education at technical school and then get a job. The idea of studying further was not even an option, and matching his interests with the school he went to was not something to worry about.

After school he worked in the same job, even though he was bored and frustrated with it, until we emigrated. His first job in South Africa was in the same technical field, and after a year he suddenly decided to resign without making any other plans or preparations.

I saw his sudden resignation as a selfish, irresponsible move that left us trying to cope on my intern's salary. He decided to abandon his technical skills, and during the next few years he changed jobs frequently in search of a more meaningful career. I felt angry and abused. The more often he changed jobs, the more insecure we became financially, and the bigger was my responsibility to provide for both of us. At times he had no work and no salary, and I was the sole breadwinner. I did not see that our marital system was homeostatic, and I believed that I remained married because he would not be able to survive without me. I failed, for all that time, to look a bit deeper and confront some of my own fears and inadequacies.

### Professional Training and History

Guy (1987) elaborates on dysfunctional motivators for entering a career in psychotherapy. He feels that a therapist's emotional distress and desire for self-

healing may create dysfunctional relationships if the therapist attempts to meet his own and not his patient's needs.

At the same time, reserving the role of psychotherapist for those free from any emotional distress or psychopathology may be naïve if not impossible. Emotional pain may, in fact, not be an entirely dysfunctional motivator. Individuals who enter the field in a need to find resolution and relief may in fact become very effective therapists as a result of their own healing and progress, in spite of the potentially dysfunctional aspects (Guy, 1987, p. 14). The "wound" of personal distress in a therapist's own life may render him more empathic, and all of us have, at some stage, thought that personal experience may be the best teacher.

During my training, and even as a young professional, I was unaware of the connection between my personal wounds and my choice of psychotherapy as my profession. The connection became clear through the self-reflection provoked by my struggle with the thalasseemics. I was trying to heal others but hoping to heal myself (Hilton, 1997c). Sussman (1992) believes that many therapists are very hungry to be parented themselves. He adds that they are also more likely than average to be the oldest sibling, most of them learnt to take responsibility very early, to sacrifice, nurture and strive to be the ideal child. Henry, Sims and Spray (1973) comment that, in some respects, occupying a superior sibling position may be similar to playing the role of the therapist. Sussman also makes the point that the overall results of many studies indicate that psychotherapists often go through an intense struggle for independence from their families. He concludes: "Those individuals who choose to become therapists typically manifest significant psychological conflicts of their own. When adequately understood and mastered, however, such difficulties may ultimately allow therapists to be of greater help to their clients" (p. 239). He summarises the motives for practising psychotherapy into several categories, such as instinctual aims (e.g. aggressive, sexual, sadistic); motives stemming from the early development of the self (e.g. strong narcissistic needs); motives relating to object relations with strong dependency needs, separation anxiety and the need to control and dominate others. Sussman also points out that therapists should remain aware of their own psychological functioning and resolve their own difficulties adequately (p.

243). A balanced perspective is one in which both the positive and negative, the constructive and destructive, are acknowledged (p. 258).

My personal life made its impact on my professional role through unusual insights and their obverse, namely blind spots. In time, I think I began to derive more learning from difficult clients and from my personal life and crises than from the colleagues who inspired me earlier in my career. In particular, the work with the thalassemia groups and the personal struggle that evolved had a major impact on my personal and professional examination of my past and present development.

Over the past 12 years, my developmental process in my career has varied greatly. At times it was intense and continuous, and at times slow and painful. My age on entering training, other experience, confronting a personal crisis, recovering from a dysfunctional family of origin, are just some of the factors that seem to increase the pace of development (Skovholt & Ronnestad, 1992). My level of anxiety is gradually decreasing as a result of increased professional experience. However, it also increases and decreases in recycling loops. Confidence can be lost during a time of career transition or unusual stress related to work with clients (Skovholt & Ronnestad, 1992). During the 5 years of my professional career in Yugoslavia, my confidence gradually increased, but it sank to its lowest level when I emigrated and during the first 2 years of rebuilding my professional self. The recognition I started receiving at Coronation Hospital greatly improved my confidence, but then the struggle I experienced through the process with the thalassemia group and V.H.'s dying gave my confidence another battering. This struggle and decline in confidence provoked continuous self-reflection, which was long overdue, and which allowed me to work through some of the issues affecting my professional work and, in the end, gain a more realistic sense of my professional and personal selves.

Skovholt and Ronnestad (1992) discuss evolution of the professional self by way of continuous professional reflection in a process where personal life becomes more accurately understood and integrated into professional life. They propose a model of professional development which follows four stages (Skovholt & Ronnestad, 1992):

1. exploration stage
2. integration stage

3. individuation stage
4. integrity stage. (p. 16)

The exploration stage relates to the time just after graduation when the psychotherapist is developing professional experience. Lack of success and a sense of inadequacy are common experiences at this stage. With some years of professional experience one enters the stage of integration, which is characterised by building a professional identity. There is an evolution of style and more satisfaction through successful work. The individuation stage relates to highly personalised growth and can last between 10 and 30 years. Clinicians who have practised for 25 to 35 years and who are between 60 and 70 belong to the stage of integrity, which is characterised by the richness of one's individuality.

During the years of training for my degree in psychology, I was most influenced and perturbed by some of my older colleagues, who became my mentors. At this stage of a therapist's professional development, learning occurs primarily through imitating supervisors. Lacking professional confidence necessitates a supportive attitude from supervisors or mentors (Skovholt & Ronnestad, 1992). At this stage the trainee is insecure and dependent, with little insight into his or her motivation for practising therapy, and has conditional autonomy.

The most important mentor in my professional development was Rade Marjanovic. A cynic and a very unconventional thinker, he created a supportive yet most challenging space for my learning. His influence on my personal life as a positive male figure has been very healing. His presence at good and at bad times, his consistency and his ability to remain his real self, taught me an important lesson about integrity, even when I had difficulty accepting some of his viewpoints.

My training at Belgrade University went smoothly, without any difficulties. The training gave no preference to a specific orientation. The psychodynamic and cognitive orientations were as popular as ever, but during the seventies some relatively new orientations had started to appear and were attracting a growing number of followers. Transactional analysis was one of these new wave therapies and family therapy was another. After completing my internship I defended my thesis, "Links between certain aspects of fairy tales and children's respective developmental stages", and graduated at the beginning of 1988.

My first job was part-time, pre-school work, where I ran workshops for parents. The cognitive-behavioural training organised by Oxford University's Department of Psychiatry, in which I participated at the beginning of 1989, proved a very helpful resource for teaching parents behaviour techniques. Looking back, my choice of the cognitive-behavioural approach makes a lot of sense in terms of my developmental stage and reality at the time. We invent the theories of the world to fit into our experience, and they fit not just because they mirror a particular reality, but because they sustain a particular version of our constructed "realities" to which the theories are linked (Steier, 1985). We need to acknowledge and understand the self-referential nature of the relationship between our theories and our realities.

Personal experience has a profound influence on one's choice of a professional model (Hirschhorn, 1999). At the time I believed in objective science and logic. As I saw it, cognition relied on logic and objectivity and was strong, powerful and in control, while emotion meant subjectivity, weakness and imperfection. My belief system at that time says a lot about my personality and my defence system, which allowed me to survive some of the very difficult times in my family. On the other hand, as an inexperienced therapist I needed a clear model as a preliminary to finding my personal style (Hirschhorn, 1999), and cognitive-behaviour therapy provided this clear model at the time.

Skovholt and Ronnestad (1992) write that after graduation, therapists enter an exploration stage, usually lasting for about 2 years. The major influences at this stage are from work settings and professional training. There may be a rejection of some previously mastered conceptual ideas or theories as the therapist is confronted with the complexities of work tasks that demand new learning. Anxiety and lack of progress are common themes. In the instances where I experienced lack of progress, it seemed that family dynamics were an important factor, but my knowledge of family systems was limited. This realisation made me ready to embrace a new theoretical frame – systems theory.

When, a year later, I got the chance to work at the Institute of Family Therapy for Alcoholics, with a team of family therapists using a one-way mirror, I grabbed the opportunity. This work proved to be a starting point for following a new path – family therapy. Most of the senior family therapists at the Institute followed a

strategic approach. This approach emphasised the social context of problems, with the therapist using strategies to change a family's destructive patterns (Becvar & Becvar, 1996). Learning about systems and interventions expanded my flexibility and gave me a broader theoretical perspective for understanding human problems. However, some of my personal issues, such as my need for power, expressed through occupying the hierarchical position of the expert, were maintained through this approach. The strategic therapist is seen as an expert who, by using strategic interventions, produces a change in the family, and the therapeutic situation is characterised by a hierarchical organisation. In terms of its instrumental nature, hierarchical frame and non-inclusion of the therapist's context, the strategic approach belongs to first-order therapy (Hoffman, 1985).

At this stage my professional development was characterised by corrective learning with more emphasis on correction and less on support (Skovholt & Ronnestad, 1992). My senior colleagues still constituted the major influence in the learning process: Dr. Gacic, a psychiatrist and one of the leaders in family therapy, director of the Institute of Family Therapy for Alcoholics, developed and practised an ecosystemic model of alcoholism. At times we had between 15 and 20 people in the therapy room, all significant others of the patient, such as close family and extended family, employer, colleagues from work and even friends. Dr. Gacic's ecosystemic concept was extremely successful in the treatment of alcoholism, and attracted many followers. Exposure to the work of Jelena Srna, Julija Bala, Olivera Markovic and Sanja Pecujlic and participating in a team increased my flexibility, knowledge of family interventions and ability with the corrective process.

After 2 years at the Institute, I spent another 2 years working with autistic children, first at the School for Autistic Children and then at the Institute for Autistic Children. During that time I was greatly influenced by colleagues who practised the Milan approach. This influence was apparent in my frequent use of paradox techniques. In 1990, when the opportunity arose to participate in a year-long family therapy course organised by the Cardiff Family Institute, I saw it as an opportunity to build up my theoretical knowledge and expand my practical skills. The course leaders, Elsa Jones and Dr. Renos Papadopoulos, were excellent teachers. During that time consolidation was the major element in my process. I had increased

freedom in the choice of concepts and ideas that would fit in with my style. At the end of the course I passed an examination which included a written analysis of my work with families with autistic children.

The next stage, say Skovholt and Ronnestad (1992), is the integration stage, characterised by the need to develop professional authenticity, with clients becoming more influential as a source of learning. My working style became less rigid and I became more eclectic, trying to fit theories with clients instead of fitting clients into the theories, as I had done in the past. At this stage, in line with Skovholt and Ronnestad's description, I had been exposed to different work settings and had worked for a good number of years after completing my training

This was a period during which I experienced a lot of satisfaction in my work, and other colleagues often recommended me when there was a complex case. After my first (and very successful) programme on State TV on children with problem behaviour, I was often invited to take part in educational programmes.

At the beginning of 1991, I took a position as lecturer in General Psychology at a secondary level school, but as I have already described, life changed dramatically in June 1991 when Yugoslavia became embroiled in civil war. A year later I resigned, and in June 1992 my husband and I left the country.

In South Africa, I went through a process of evaluation of my degree, followed by a year of supervised internship at Sterkfontein Hospital. I think that my emigration and the changes I faced in the course of it led to professional stagnation, if not deterioration. During the internship, I struggled to find my position within the system. I felt awkward in the role of "student" when I already had several years of pursuing a successful professional career behind me. Perhaps one reason for my great distress lies in the similarity between this situation and my incongruent position in my family of origin.

In my family we had the game in which I was asked to behave as, and take the responsibilities of, an adult. When my mother needed me to do certain duties, I was considered an adult, while at other times I was expected to remain within a child's reality. This game and its rules often confused me, and I felt a very similar confusion during my internship at Sterkfontein Hospital. When there was work to be done and the Principal Psychologist wanted to make sure that it would be done well,

he would call me to do the work. He would, in front of the other interns, call me an “expert”. However, whenever I took autonomous decisions, I was reminded of my position as a “student”. I often felt I was on an emotional roller coaster; but I survived, although with some bruising.

During the internship, each intern gets a chance to work with a different population at the hospital’s outside clinics once a week. Every 3 months one is obliged to move to another clinic so that each intern can work in a different setting. My first clinic was at Coronation Hospital in the Paediatric Department.

At the end of the 3 months Professor Rosen, Head of Paediatrics at Coronation Hospital, was very impressed with the results of my work with families. After discussing the matter with the Principal Psychologist at Sterkfontein Hospital, Professor Rosen asked me to remain at Coronation Hospital all year, continuing with the weekly sessions. Emotionally, Coronation Hospital was like finding an oasis while walking through a desert storm. I felt at home working with families and children. The team had shown a lot of respect for my previous experience and work, which created a feeling of congruence. I felt acknowledged and accepted by the members of the team and this motivated me to do my best.

During those first 2 years in South Africa, my professional development went back from the integration to the exploration stage. Exposure to a new work setting, cultural differences and language difficulties were just some of the anxiety-provoking challenges I confronted. In 1993, after completing the internship, I registered as a clinical psychologist. In January 1994 Professor Rosen offered me a sessions (part-time) post at Coronation Hospital. In 1995 I started working on a part-time basis at a private practice in an affluent suburb, where I continue to practise today.

## CHAPTER 6

### PART I: EMERGING SELVES

#### Deconstructing the Expert Stance

When the therapist assumes a hierarchical position, this presupposes that the therapist is the expert. The therapist is wiser than the client and has all the answers, while the client has deficits that need to be addressed (Fishbane, 1998). In such a process the client may sacrifice his own reality, subordinate himself to the expert and join in invalidating his own reality (Fishbane, 1998).

Deconstruction involves questioning the margins, limits and borders of a dominant philosophy (Larner, 1995). Thus, as White (1991) points out, deconstruction of the expert stance relates to “deconstruction of knowledge” and consequently of power, and of “those so-called ‘truths’ that are split off from the conditions and the context of their production, those disembodied ways of speaking that hide their biases and prejudices” (p. 27) In that process the client is given the space to become the expert himself. In my own case, it was the process of self-analysis that initially created a context for challenging and deconstructing my expert role.

Modernism was strongly influenced by the idea that power and knowledge are inseparable, and that any knowledge implies power. The post-modern approach radically challenges the modernist view of the therapist as an expert and calls for constant questioning of one’s views and theories as well as more equal and participatory therapeutic conversations (Hoffman, 1992). Hoffman (1988) regards Andersen, Goolishian and Winderman’s “problem-determined system” (1986) as a post-modern concept. Deconstructing the therapist’s expertise involves the willingness to share ideas, prejudices and theories with clients and exploring alternatives (Wangberg, 1991). Dale and Emerson (1995) take a feminist perspective in their discussion of the central importance of shifting towards a more mutual relationship in therapy, which they see as validating women’s voice. Keith (1987) shows how, at the beginning of therapy, power relates to the freedom to set up the structure and to decide how the information is to be presented. According to him, as

caring increases so power diminishes. After a number of sessions, when the relationship has been formed, power lies in the therapist's capacity to change, and to join and separate when necessary.

In 1994 and 1995, at the start of my work with the thalassemic families, I assumed that the only system that would change would be the client system, while my system would remain the same. This assumption may explain my minimal awareness of what was happening to the "observer" (to me as therapist) while observing the "observed" (the thalassemia groups). The self-reflective stance was a prerequisite to my increased ability to see myself with different eyes. My struggle to let go of the expert role was related to a perception, shared by most of the professional community, that as a therapist I am expected to be perfect, objective, knowledgeable and able invariably to place clients' needs before my personal needs (Schaefer, 1992). Professionals can be their own worst enemies. Trained to be independent and hard driving, they do not readily acknowledge when they are in trouble. Solitary battles are the most destructive for therapists because of the ease with which they can lose perspective, and to admit that they have difficulties and self-doubts proclaims failure (Millon, Millon & Antoni, 1986).

As Poland (1993) so vividly puts it, our self-portraits are often like "the delightful images painted by court artists, portrayals of loveliness with an occasional beauty mark intended to mask the idealization" (p. 219). He believes that when self-analysis takes place, the outcome is genuine inner change and outer opening subsequent to emotional work. He describes the process as a continuous flow of feelings and reflections, leading to a profound opening and a merciless self-exposure despite increasing discomfort. Adopting "other eyes" (p. 224) means the ability to expand one's vision to include one's own blind spots. One of the products of self-analysis is insight into one's self as a result of a fresh perception of oneself (McLaughlin, 1993). Skynner (1989) maintains that self-reflexiveness brings increased alertness, a sense of heightened interest, greater consciousness, new knowledge and personal and professional growth. Skynner concludes that rediscovering and reaccepting oneself as a result of self-reflexivity is a painful process but regards it as "bitter medicine that can ultimately heal and lead to growth" (p. 177). The capacity for self-analysis requires the capacity to generate and sustain

interest in one's own inner experiences and to enjoy the process of exploring and understanding oneself (Demos, 1993). Mastering one's inner experiences thus requires affective and motivational investment.

Regular self-analysis promotes self-awareness and decreases the risk of negative counter-transference. Sussman (1992) examines several studies from the first half of the twentieth century that discuss how rarely psychotherapists use self-examination, and concludes that more than 60 years later the situation has not changed much. He points out that if we regard therapy as a collaborative process and the therapist as a participant in an affective relationship with a patient, then it is crucial to understand and explore the therapist's traits and strivings.

The self-reflection process I undertook resulted in valuable insights, but writing about self-analysis was another means of enriching my learning about myself (Sonnenberg, 1993). Self-analysis deepens one's understanding of self and creates a process for profound professional and personal growth. Editing one's self happens not only through self-analysis but also through the self-recursive act of writing about the process itself (Margulies, 1993). Thus I reshaped my history of myself to myself, as Margulies (1993) describes – in a spiral of self-reflection and writing about the process. Eifermann (1993) points out the value of making self-analysis public and concludes that such a process enriches the self and opens a new path to other important insights.

One of the first self-deceptions to be challenged through self-analysis was my view of my professional role. I began to see that behind my need to help was a need for power and control. By taking responsibility for others I became the expert while the client became the victim. Kotler and Blau (1989) warn that we should not be concerned about the therapists who think they do not know what they are doing. We should rather be concerned with those who think they do. Sussman (1992) points out that the role of the psychotherapist “may enable such people to gain a sense that – at least through the eyes of their patients – they are fully in control and in the know” (p. 113). Being in the expert position may minimise the possibility of self-questioning as it allows very little leeway for looking at ourselves when the process gets obstructed. Therapists, says Schaef (1992), are

growth for ourselves. Kotler and Blau (1989) insist that we (therapists) must come forward and acknowledge the existence and persistence of a great deal of psychopathology in ourselves, and must drop our defensiveness. Counter-transference and counter-resistance are, they say, universal – not rare phenomena that appear only in a few aberrant, deviant therapists.

Kottler and Blau (1989) describe failure as “neither a permanent condition nor a statement about a person’s character; rather, it is a transition stage that consists of an awareness that one’s performance in a certain area could be improved” (p. 12). These authors believe that most of us became therapists to relive our imperfect childhood. They maintain that failure can be useful in many ways: (a) it provides information on the impact of our actions; (b) when acknowledged, failure can lead to greater commitment in helping the client; (c) in order to help clients conquer their failures, the therapist must overcome her fear of failure and learn how to deal with it; (d) failure provokes self-reflection, reassessment and planning for new directions; (e) failures can teach us about our own limits; (f) failure can teach us about appropriate risk-taking; (h) when shared with the client, failure can promote more open and free space for the client to reveal the struggles of his or her life. Kottler and Blau (1989) go on to say, “admitting mistakes, errors and misjudgements can sometimes initiate a turning point during treatment”, and “it requires courage and humility for a therapist to say ‘I don’t know’ in response to a client’s plea for answers” (p. 72). Each time we experience failure, unresolved struggles can be easily triggered.

One of the most common reasons for therapeutic failure is counter-transference. Failure to recognise how the therapist’s issues pollute those of the client often surfaces in the therapist’s reactions towards the client, such as avoiding provocative, confrontational expression, being over-directive or over-reacting emotionally. Kottler and Blau (1989) believe that failure is not just inevitable: it is also a potentially useful component of the therapist’s learning and growth. They maintain, as well, that by engaging in continuing self-reflection the therapist can progress and become more effective in her future therapeutic interventions. They believe that the seeds of growth and constructive change lie in the therapist’s ability to examine, with the client, the errors and failures that sometimes take place during therapy. They describe the following five stages of failure:

1. Illusion is a phase of denial in which the therapist searches for a source to blame. This search provokes fear, anxiety and guilt, along with the awareness that something is not turning out the way it was expected to do.
2. The stage of self-confrontation results in the therapist's awareness of her responsibility for what went wrong.
3. The search phase is characterised by a more open and realistic seeking for information, as well as intense self-study.
4. The resolution phase occurs when the therapist, having opened up to new resources, gains new insights and identifies new directions and perspectives. The therapist accepts her part of the process that led to the failure.
5. The application stage refers to new learning and professional growth that emanates from confronting failure, resulting in an appreciation of one's vulnerability.

### Searching for Self: Birth of the Second-order Stance – 1995 and 1996

#### *Professional Self*

For me, 1995 and 1996 were years of intense self-analysis, which resulted in a concentrated search for theoretical and practical concepts to better my professional self. My increased awareness of the learning possibilities that Coronation Hospital might offer prompted me, in 1995, to start negotiating with the Superintendent of the hospital. He supported the idea of creating more posts for the Psychology Department and applying for training accreditation from the Professional Board for Psychology. In 1995, after several months of meetings and negotiations, the Rand Afrikaans University (RAU) agreed to use Coronation as a clinic for training their intern psychologists. My overseas experience was recognised, and I was promoted to senior psychologist. Interns attended Coronation twice a week and I provided regular supervision.

My experience with the medical staff, my conversations with the thalasseemics and the feedback from the workshop I presented to the paediatric staff pointed to a lack of training among the medical professionals in areas related to the psychological and emotional side of illness. In order to address these issues I developed a long-term plan that would combine workshops on the psychological and emotional aspects of compliance with discussions on useful approaches to the more difficult or emotional aspects of their work. The head of paediatrics welcomed my idea that the interns and I should attend the weekly academic medical meetings and present issues related to the psychological domain once a month.

In 1996 I was given two more posts and several offices, and the construction of a one-way mirror for training purposes was completed. At the end of the first year, the interns' very positive feedback on the learning and supervision at Coronation Hospital prompted RAU to express an interest in placing their interns there on a full-time basis. It was agreed that as soon as the professional board had approved the training programme I had submitted and Coronation had received official accreditation, we would start a full-time training programme. In 1996 I also completed my proposal for a doctorate and submitted it to the University of South Africa (Unisa), while in June I prepared and presented two papers at the World Family Therapy Congress in Israel. One paper presented the work carried out with a diabetic child by a paediatrician colleague and me, and the other related to my work with thalassaemic children and their families.

This was a time when my professional development involved both separation and relatedness, where relationships with others became central. I entered the individuation stage, which is characterised by highly individualised growth that adds to one's authenticity (Skovholt & Ronnestad, 1992). The great challenge of this stage is to "settle down" and at the same time explore and push oneself. Skovholt and Ronnestad (1992) say that, while there is often great satisfaction during this stage, there may also be great distress, with clients and personal crises becoming major influences in one's life. There is a greater need "to sound like oneself and there is less need to be these other things" (p. 81). One is usually at the position of supervisor and the self becomes the "elder professional self" (p. 22).

For me, during this phase of individuation, my work with the thalassaemia groups became a major source of influence. Perhaps because of death-related anxiety, the work was particularly traumatic and difficult. However, my distress led to an examination of personal and professional issues, which subsequently enhanced my professional competence. Haber (1990) enumerates some of the cues related to fusion or dissociation within the client system, such as dreading the appointment, experiencing and not expressing anger with the client, feeling impatient, and blaming someone else for the problem. Rolland (1994) examines the personal themes of professionals working with illness and loss: how professionals' own family backgrounds affect their beliefs about health and their interactions with patients and

families; how important it is to accept personal feelings in reaction to illness and loss, as well as acknowledge human limits; the need to identify life-cycle synchronicities in relation to a personal reaction of distancing or over-involvement; the need for a support system and the importance of self-exploration related to illness and loss in the form of psychotherapy for professionals. The strategies suggested by McDaniel et al. (1992) provided helpful guidance in my work. These authors describe several important points of focus:

1. respecting family defences and removing blame
2. maintaining communication between family members
3. reinforcing family identity
4. eliciting family illness history and meaning
5. providing psycho-education and support
6. increasing the family's sense of agency
7. maintaining an empathic presence with the family.

In 1996 a number of significant shifts occurred. In my professional role, the use of self and self-disclosure provoked more honesty from the thalassemia group. My personal process moved from awareness of my failure to a deeper search for the meaning of my emotional struggle with the thalasseemics, which led me to deal with unresolved issues related to my family of origin (Byng-Hall, 1987). A therapist's childhood experience of helplessness may result in defence against feelings of being out of control or helpless which, according to Sussman (1992), would render the therapist unable to tolerate the uncertainty inherent in the therapeutic process and lead her, instead, to take refuge in a dogmatic and preconceived approach. Sussman identifies a difference between therapists who view psychotherapy as a science and those who believe it to be an art. Those with the scientific approach need to feel powerful and intellectual, and they reject any traits of weakness and emotionality. Those who see the therapist as an artist tend to be gentle, affectionate, sensitive and altruistic. The scientific type attempts to achieve a sense of security through a powerful and omnipotent self-image, while the altruistic one attempts to achieve it through a kind of godliness, and cultivates selflessness and loving attributes. Sussman points out that the compulsive need to nurture may be fulfilled at the expense of the client, as all the "evil" in the consulting room is situated in the client.

My literature search for new input in respect of my professional role led me to the material on use of self in therapy and the therapist's participation. Seeking

information and getting more knowledge about the self heightened my awareness of the emotional nature of my self (Carstensen, Isaacowitz and Charles, 1999). The nature of the self has intrigued many writers and philosophers. For the ancients, the idea of self was usually implicit in the concept of the soul, which was conceived of as non-material, and the essence of the human being (Baldwin, 1987). The famous Descartes dictum, "I think, therefore I am", was responsible for creating the subsequent dualism of body and mind and the emphasis on the objective, materialistic side of life above the subjective and the non-conscious.

It was not until the advent of philosophers such as Kierkegaard, writers such as Dostoevski and Tolstoy, and clinicians such as Freud, Jung and Adler, that the subjective world began, once more, to be explored (Baldwin, 1987). Psychoanalysts define the concept of self as an integrated conception of one's self in relation to one's experiencing, thinking, valuing and acting (Baldwin, 1987). Although many agree that the self of the therapist is present in therapy, there is a great deal of controversy on how the therapist should deal with his or her self.

The psychoanalysts traditionally believed that the person of the therapist should not be visible to the client. The therapist should be as neutral as possible and should submit himself to a training analysis in order to prevent the damage that could be done if the analyst did not master his own conflict and neuroses (Aponte & Winter, 1987). This training analysis was intended to protect the client from the unconscious harm that therapists could inflict through their own unresolved problems. Freud's term, "counter-transference", refers to unconscious projections onto patients, which could cause analysts to react in ways that could cause damage to their patients (Aponte & Winter, 1987).

Under the influence of humanistic psychology, the self of the therapist became an active ingredient in therapy (Baldwin, 1987). For the existentially oriented psychotherapists, experiencing the full awareness of one's being was a central part of their approach.

With the development of family therapy, we find that some therapists are more technique oriented than others when it comes to the training of family therapists. Discussing the use of self, Titelman (1987) points out that some, like Minuchin and Haley, believe that the therapist's awareness of personal self and

working on the development of the self are not relevant to becoming effective. On the other hand, he says, there are others like Bowen, Framo and Satir who believe that attention to the therapist's self is an important component of his or her effectiveness. Baldwin (1987) shares his personal view on the therapeutic process, as follows:

It is an intensely real and personal act – that of letting go – putting one's belief in one's self and in the self of the other on the line – exposing one's true and deepest self; in a sense, going naked into the encounter – allowing oneself to become truly vulnerable. (p. 42)

Baldwin also recognises that there are harmful ways of using one's self: "Some people who call themselves therapists are not healers, because they are too busy defending themselves" (p. 51). Satir (1987) points out that the therapist and the client inevitably impact on one another and that this occurs regardless of theoretical approach. She advises, "while therapists facilitate and enhance patients' ability and need to grow, they should at the same time be aware that they have the same ability and need" (p. 21). According to her, the key to healing lies in the emotional honesty between therapist and patient. Therapy is, she feels, an intimate experience in which both sides become vulnerable.

Several factors such as genuineness and connection, encouragement and humour, trust and respect, and empathy and warmth, are particularly valuable to the therapist's use of self from the point of view of any family orientation (Shadley, 1987). In respect of self-disclosure, most therapists feel that paralleling their own lives with the client's is a useful strategy, but there are several who state that they are uncomfortable about actually discussing or disclosing any of these parallels to their clients. The use of self relates to the therapist's emotional response to the client – the verbal and non-verbal expressions of her feelings and her self-disclosure (Shadley, 1987). Smith, Osman and Goding (1990) note that the therapist's emotional experience has often been minimised and denied. However, these authors suggest that the therapist's awareness of her emotional world and constructive use of it can improve her effectiveness. In such a process, failure is seen not as a final point but as a transition stage where acknowledgement of failure may lead to improvement in therapy (Kottler & Blau, 1989).

Hoffman (1993) emphasises that therapy can be viewed as forming a shared consciousness, and that making therapy too much a matter of the rational leaves out a huge part of the endeavour she calls creating a “shared unconscious” (p. 41). According to her, “second order” views are one step removed from the process. This allows one to see more clearly otherwise hidden influences and how the therapist’s meddling is making the matter worse. She criticises social constructionist views on emotions, which are seen just as one more part of the complex web of communication and not as having a special status as interior states. She recalls:

I began to have doubts about the distance between clients and therapist. When unobserved, I would show a far more sympathetic side to clients than my training allowed. I would show my feelings, even weep. Where appropriate, I would share stories from my own life. I would openly assume responsibility if the client had a complaint about therapy, rather than treating it as evidence of resistance. (p. 125)

Innovations in second-order therapy include a collaborative and affirmative framework, openness about our ideas, and being there for our clients. Hoffman (1993) elaborates as follows:

I deliberately try to give comfort, through expressions of sympathy, sharing of similar experience or even touching people on the shoulder as one would a friend. This is almost the reverse of what I was trained to do as a family therapist. I am not looking to do away with all boundaries, but the distant position I used to take in the face of justifiable grief or anger seems incredible to me now. (p. 157)

According to Kottler (1992), one of the major sources of poor progress in therapy comes from the therapist’s rigidity regarding what constitutes reality. Feeling understood seems to be one of the essential components of client’s transformation (Kottler, 1992). Starcevic and Piontek (1997) hold that the understanding that occurs between the therapist and the client is an interpersonal process that entails emotional interaction between the two sides and makes emotional knowing possible. In order to empathically understand the client, say these authors, the therapist needs to be able to relate emotionally to the client’s process. Kottler concludes that empathy and compassion are the key components for clearing the way for therapeutic progress. This requires the therapist to abandon the observer stance and become a participant in the process. Such a stance may force the therapist to face her vulnerability,

resulting in emotional shifts within the therapist, which subsequently enhance personal and professional growth. The idea that the client may play a role in promoting the therapist's personal growth and professional maturity has been a controversial one. Yet as Guntrip (1975) points out, "there must be something wrong if an analyst is static when he deals with such dynamic personal experiences" (p. 155). It seems that the idea of the client's contribution to the therapist's life is more acceptable if it is used to further facilitate the client's treatment. A number of therapists report that they have experienced significant increases in introspection, self-reflection, sensitivity and self-reliance in their personal lives as a result of promoting similar changes in the lives of their patients (Guy, 1987). Gurman (1987) concludes that in different therapeutic approaches there will be different characteristics influencing the effectiveness of the therapist, and different "selves" may be required by different therapeutic approaches. Skynner (1989) argues that the therapeutic process should not just benefit our clients. For him, helping others is not just an altruistic act but is also motivated by our unmet personal needs. Instead of pretending that we have no needs, he proposes that the therapy situation can meet the needs of both client and therapist. The greater the benefits for the therapist, the more her or his skills will increase, producing an experiential growth in personal understanding and competence. Skynner says therapists often turn away from the lost parts of themselves, which could complete them, and search for these in their patients instead. He warns that our work can be destructive when it creates an evasion of the truth about ourselves.

Gurman (1987), talking of the variables influencing outcome in therapy, mentions the following:

1. The therapist's "style" and, more specifically, the therapist's activity, have proved to be important variables in predicting dropouts, with more active therapists having fewer early dropouts.

2. "Relationship skills" such as warmth and empathy and similar relationship building skills seem to play a role in achieving positive outcomes, whereas confrontation, lack of structure and support tend to lead to negative outcomes. (pp. 116-118)

Skynner (1989) maintains that psychotherapy is most effective when the therapist can include herself in the process and thereby initiate a powerful, mutual learning process in which both client and therapist change and grow. He advocates

that therapists should use the whole of their personality, including the aspects they find problematic. Speaking about the nature of the psychotherapeutic process, he says, "I soon discovered that it could also mean that it is not only the group, but also the therapist as part of the group, who undergoes the treatment" (p. 105). He describes psychotherapy as a reciprocal, two-way process where the failure of either patient or therapist to change inevitably limits the beneficial effects for both parties.

Self-disclosure, as one aspect of the therapist's use of self, has been widely discussed and emerges as a contentious issue in psychotherapy (Cornett, 1991; Goldstein, 1994; Hill, Mahalik & Thompson, 1989). The psychodynamic perspective persists in its view of self-disclosure as a counter-transference problem, whilst humanistic psychology sees self-disclosure as evidence of the therapist's empathic attunement, genuineness and authenticity, which facilitate client growth (Cornett, 1991). Goldstein (1994, p. 419) defines self-disclosure as "the therapist's conscious verbal or behavioural sharing of thoughts, feelings, attitudes, interests, tastes, experiences, or factual information about himself or herself or about significant relationships and activities in the therapist's life." Hill, Helms, Tichenor, Spiegel, O'Grady and Perry (1988) have found that clients perceive therapist self-disclosure to be the most helpful of nine measured therapist response modes (approval, information, direct guidance, closed question, open questions, paraphrase, interpretation, and confrontation as well as self-disclosure). These researchers also found that although clients rated disclosure as very helpful, therapists generally found all disclosures to be less helpful. Garfield's (1987) research similarly found that disclosure by therapists made them more human to clients and decreased the power differential, but was threatening to therapists because it made them feel vulnerable. Cornett (1991) points to the difference in the psychoanalytic and humanistic approaches, namely that psychoanalytic thinking sees self-disclosure, in the main, as contraindicated, while humanist and existential therapists view self-disclosure as being based on therapists' use of authentic self. Jourard (1971) views self-disclosure as providing a context for a more authentic therapeutic relationship. Rosie (1980) found that the use of self-disclosure relates to therapists' age and experience, with parallel increases in age, experience and the use of self-disclosure. Other therapists point to the importance of theoretical orientation as a crucial guideline in the use of self-disclosure (Simon, 1988).

The renovations continued at Coronation Hospital throughout 1995 and 1996. It took everyone a year to get used to it, and then the chaos was accepted as normal. From the end of 1995, my approach expanded to include a number of different perspectives, such as:

1. developing a collaborative frame work between patient and health care provider
2. maintaining a continuous dialogue with the patient
3. regarding education as a necessary but not a sufficient condition for compliance
4. focusing on negative or maladaptive beliefs
5. providing support and creating more family support for the patient
6. discussing possible setbacks and relapses as a way of decreasing non-compliance rates (Farberow, 1986).

At the end of 1995, while talking about the past during a session with patients, I discovered the presence of past beliefs which had made an enormous impact on compliance. Events in the past have a powerful influence on the present and may impose severe constraints on how things might develop in the future. Such a position, say Boscolo and Bertrando (1993), is a self-reflexive loop which connects past, present and future. These authors suggest that the therapist may need to focus on the past in order to expand the possibilities for the present and the future. The client's past may also prove to be a vital source of meaning which can help the therapist to understand the way in which the self of the client is constructed.

Difficulties with compliance have been associated with patients' beliefs and the influence of these beliefs on their perceptions of illness, health care providers, and treatment (Farberow, 1986). Exploring these beliefs may be vital for improving compliance. Boscolo and Bertrando (1993) note, in this regard, that the group myth is an expression of beliefs shared and implicitly accepted by members of the group, although this may not necessarily be stated in so many words. The myth is part of an evolutionary process, and Boscolo and Bertrando suggest that bringing members of the group together may enable them to develop a new belief system.

*N.Ch.:* When R. died his parents told everybody that desferil killed him. They said, "Don't use desferil, it will damage your child." We were worried. You can't just use it. You think it will kill your child.

*Ther.:* Is that when most of you stopped using the pump? That was some time in 1992 or 1993.

*V.L.:* Yes. We were scared.

In the other group the same story surfaced.

*S.A.:* We listened to R's parents. You are scared. You are put desferil every night and my child won't live long. They told us that desferil killed him and we believed them.

I felt that this wrong belief should be dealt with, but I could not make out where it came from. In search of the answer I spoke to the doctors who remembered R's death. One of them said that when R. was dying from heart failure, the last option was to try and alleviate stress on his heart by giving him 24-hour desferil treatment. The reasoning was that heart failure was the result of iron overload, and desferil bonds with iron and leaves the body through the urine. The 24-hour desferil treatment might therefore take just enough iron from his heart to prevent further damage and death. However, his heart had too much iron and despite this measure, R. did not survive. It seems to me that because his parents saw him dying while on this treatment, they blamed desferil for his death. In their shock and anger they looked for someone or something to blame; but their story about desferil had disastrous effects on the whole group. As soon as they heard the story that desferil had killed R., they all stopped using it. This led to major iron overloads in the following year and a half. The belief that desferil had killed a patient was addressed through discussions over the next several sessions. In the groups, I explored how the wrong information had led to the problem we were facing then. Parents admitted that they had started to question the story told by R.'s parents, especially after several educational talks in which the issue of desferil had been discussed. They reported that they were beginning to use the desferil pump again, and although it seemed they were not yet using it as often as prescribed, I hoped this would subsequently come right.

Lal Sharma (1995) describes several studies where the therapeutic process benefited from therapists' expressing their feelings and facilitating open communication. When the therapist reveals herself, the client is likely to disclose more. The client may also be able to identify with the therapist and thus develop greater self-honesty. Moreover, the therapist's self-disclosure deepens the client's perception of her as a real person, and in self-disclosing, the therapist participates

actively in an immediate relationship with the client, which facilitates the therapeutic process. At the most basic level, psychotherapy rests on the dyadic effect, which implies interpersonal reciprocity, and this further implies that self-disclosure by the therapist will stimulate self-disclosure by the patient (Jourard, 1971; Simonson, 1976). Simonson's (1976) comparisons of a number of studies show that self-disclosing therapists are viewed more positively by their clients. Lal Sharma (1995) concludes that counter-transference can be useful to the therapist when "the therapist is honest enough to use it as an opportunity to explore his own conflicts and prejudices" (p. 251). Cornett (1991) points out that using self-disclosure is as risky as using any other intervention, while David and Erickson (1990) emphasise that clinicians cannot *not* use self in therapy.

As may be seen from the following excerpts from my sessions with thalassemic families, I began to disclose my personal struggle and feelings of uncertainty and insecurity (Lal Sharma, 1995). In one of these sessions, my disclosure about my own struggle led to more disclosure from the group and to deeper emotional expression.

*Ther.:* I was thinking of something. This work with you is my first experience with serious illness. At the beginning it was all about iron overload and my role was clearly to help with that. Now I am confused about my role. I used to think that confronting parents was very important. But lately I am wondering if just listening and sharing other stories may not be more useful? Just being there – I am going through something – I don't know what – development – I feel a bit lost. I am not sure any more what is the right way.

*V.G.:* But even when you spoke to us about desferil I got to realise how important the treatment is. I must admit that after those sessions I have been faithful with treatment lately.

*Ther.:* I don't know what helps.

*V.G.:* What helps me – what I want out of this. Sometimes I am very bitter, sometimes I am very caring and sometimes I am very envious that other people have healthy kids and they don't even care. That angers me. You go through so much, many different emotions. I want to know if what I am feeling – is it normal?

*S.A.:* I also feel sometimes angry that other people have normal kids and they don't care. I think, "God you have given me a sick child, why didn't you give me a normal child?"

*Ther.:* It feels so unfair (*touching S.A.'s hand*).

*S.A.:* Yes (*crying*).

During that session, V.G. disclosed her problem with alcohol abuse. It seemed that alcohol served as an escape mechanism that alleviated her stress (Taylor & Aspinwall, 1990). According to her, it “helped to dull the pain, the worry. It made me less scared” (referring to her fear of her daughter’s dying). In the next session we followed up by discussing the impact of her self-disclosure.

*V.G.:* He (*husband*) got such a shock that I could talk to you here about it. He said, “You told Zana that you have drinking problem?” I said, “Yes I did, and I am not afraid any more. I don’t see why I must hide it any longer.” And as from that day I haven’t been drinking spirits. S.A. phoned to see how I am feeling. Even we (*referring to husband and herself*) got much closer after that discussion, he has been coming home earlier. I said to him that if he comes earlier I am not so alone and worried all the time.

*Ther.:* When we spoke last time, I had an impression that communication between your husband and you has been a problem for a long time. Now it seems it has improved so quickly?

*V.G.:* Because I discussed it openly for the first time here, in the group. I was also surprised by myself and even more that I could pull myself together and stop drinking after I told you.

In families with a member suffering from serious illness, feelings, thoughts, worries, fears and anxieties are not discussed, but are kept inside each individual, leading to further problems (Georganda, 1990).

*V.G.:* I never even knew that I have so much of feelings inside of me. I used to want to talk about my feelings but I thought it is just me going through all those feelings. Am I going mad? That is what I used to feel.

*Ther.:* What time are you referring to?

*V.G.:* Before we began the group and our talking. There are certain things you cannot talk so easy unless someone like you helps.

*Ther.:* Last time you shared with us how vulnerable you are. Would there be a difference if your husbands were there?

*V.G.:* We were brought up different. Even if you go to the funeral, or to your friends, you don’t sit with man and talk. But before it was even more strict with covering yourself. But we are not so orthodox now.

*Ther.:* It would really be something different to get women and men talking?

*V.G.:* Not now. It is very scary. Lots of times we don’t open to them to tell them what we are feeling.

*Ther.:* Maybe they feel the same?

*V.G.:* It is possible that they feel the same and don’t know how to discuss it and they keep superficial topics, neutral.

*Ther.:* Perhaps it is general – in all cultures men find it difficult to talk about their emotions. One of my male clients said that they learnt to keep strong. We, as women, in spite of our differences in culture and religion, we seem to find it easier to open up.

In Gerber's (1986) opinion, most approaches and much of the literature seem to focus on the simple, one-dimensional approach in improving compliance rates, and fail to address the complexity of compliance. According to Gerber, the literature over-emphasises the threats and stresses related directly to illness, while other factors are often ignored or dismissed as of secondary importance. For him, maintenance of emotional equilibrium often has significant motivational implications for compliance.

*Ther.:* You look very pale (*to S.A.*).

*V.G.:* It was her birthday. And her mother passed away last year.

*S.A.:* It was my first birthday without her (*tearful*).

*Ther.:* How did you get through the week?

*S.A.:* It was depressing week (*crying*).

*Ther.:* Did you visit her grave?

*S.A.:* She is in Durban.

*Ther.:* And do you have a special place where you can sit quietly and connect with her?

*S.A.:* I talk to her in my mind.

Despite the allure of techniques, what seemed to count for the group was the warmth and understanding from me as well as from each other (Pocock, 1997). "Having someone there for me" seems to tap into a key experience of the collaborative approach (Pocock, 1997, p. 287).

*V.G.:* We must share these moments. I feel that her (*S.A.*) and I got much closer by coming here for sessions.

*S.A.:* Yes.

*V.G.:* And we both agreed that it does us a lot of good. But we didn't have a session with you last month. Then we allowed ourselves to get depressed. We were talking about that this morning. We just want to let you know that you are very important and you play a big role in our lives.

*Ther.:* And how do you deal with the fact that at times coming here makes you more depressed?

*S.A.:* In the beginning we just didn't want to talk about it.

*V.G.:* But we both feel that if we had someone to speak to us from the beginning, maybe we wouldn't harbour so many feelings of hurt and depression. It wouldn't get so bad.

*Ther.:* Well, maybe it is also timing. And it is not so easy for me to decide if I should be more active or keep quiet.

*V.G.:* I feel that we had our eyes opened. I feel it is important. I went to this psychologist and he just listened and kept quiet. But this is different. And also

that I listen to others and I see that I am not going out of my mind. They are going through the same. It is normal.

*S.A.*: It makes to know that you are not the only one. There is somebody else that feels like you and can understand you.

Many families with seriously ill members are uncomfortable talking about death (McDaniel et al., 1992). In one of the sessions during this period, I attempted to discuss thoughts about death, but dropped the subject in the face of the discomfort expressed.

*Ther.*: Do you think of death? And your child, and what will happen?

*V.G.*: I don't think about that at the moment. Now it is fine. I think of that only when it is her birthday. Then it reminds me. I don't like talking about that.

The issue of communication with their husbands and feelings of loneliness surfaced in one of the sessions.

*V.G.*: I said to S. (*her thalassemia daughter*) you know, I think your father and me, we must divorce. We don't appreciate each other any more. And I asked her what does she think. She said, "Well you and daddy are divorcing almost every second day... and for how many years."

*Ther.*: Did you speak about that feeling with him?

*V.G.*: You know, after 13 years of marriage you need that love. You lose the confidence and you need that closeness. I thought that after so many years living together you become companions, but there is no close contact. There is no communication. There is no love. Nothing. But I am getting at the stage where I am accepting that. And that scares me. We are mostly quiet. We don't even fight any more.

*Ther.*: Is fighting better than silence?

*S.G.*: It is maybe not the best way of communicating, but at least it is communicating.

*S.A.*: Me and R., we do talk. We fight, but about stupid things, like what programme we will watch.

*Ther.*: What do you think about what V.G. said?

*S.A.*: I think there should be fighting.

*V.G.*: It is frightening. I look forward to go to work to talk.

*Ther.*: Well according to your daughter, crisis is not uncommon in your marriage. Is there something different this time to any other?

*V.G.*: I was never quiet before (*laughing*).

*Ther.*: For how long you have been quiet?

*V.G.*: It been weeks that we are drifting apart.

Families often keep an HIV diagnosis secret, and the therapist's role may be crucial in helping families to accept the diagnosis and deal with it in a constructive

manner (McDaniel et al., 1992). S.G., one of the thalassaemic children, contracted HIV through a blood transfusion, but the diagnosis was kept a secret from her. In the excerpt that follows, I question the meaning of her withdrawn behaviour. Lendrum and Syme (1992) point out that it is common for children to express their death anxiety indirectly through behaviour such as anger or withdrawal. A child's expression of death anxiety will depend on the family's openness to sharing feelings and receiving comfort. Adults often deny a child's grief in an attempt to "protect" the child, and as a result he or she may need to mask that grief. Yalom (1980) sees adult bias as an important barrier to knowing what the child knows of death. The adult's personal fear and denial of death results in a reluctance to speak to the child about death. Yalom points out that adults systemically misperceive the child's experience, assuming that the child has less awareness of death, and therefore less anguish. This results in parents generally dealing with a child's fear by offering some form of denial.

*S.A.:* R. (*her husband*) asked me the other day why the kids go to you. I told him that it helps them. They can talk to you.

*V.G.:* They enjoy it. S. (*her eldest daughter*) is so excited to see you and to play with you.

*Ther.:* They are very quiet. They don't volunteer information. The three of them are so serious. Like little adults.

*V.G.:* S. was always so responsible.

*Ther.:* Do you ever see them laughing? Like really relaxed and happy? And what about your other kids (*talking to V.G.*)? Are they also quiet like S.?

*V.G.:* No. They are very loud.

*S.A.:* Z. (*her older thalassaemia daughter*) does not like for kids to be loud.

*V.G.:* But some time before... before K. (*S.A.'s younger thalassaemia child*) was born they used to be more loud. They used to tell jokes. That was about 4, 5 years back. We used to think that they are tired. We didn't think about it in the way you are describing.

*Ther.:* When was S. diagnosed as HIV?

*V.G. (surprised):* It was about the same time.

*Ther.:* Had anything else happened at that time?

*S.A.:* Zana, you got us thinking now. Just after S. was diagnosed, Z. also fell sick.

*Ther.:* I didn't know that. What was it?

*S.A.:* Hepatitis. Maybe they are suspecting something. Z. has been asking me a lot of questions.

*V.G.:* S. used to open up a lot to my mother. I used to tell my mother to speak to her and find out what is wrong, you know. But she would never tell me her

worries or fears. That is why I was so worried when my mother moved to Durban, because she had no one to talk to. You know, the other day she asked me what are T-cells, and I explained in general that her resistance is low and that they are like soldiers that fight illness. She didn't ask what is T-cell count for. It troubled me last night. I am not sure. Like she didn't want an explanation.

*Ther.:* Perhaps she felt your discomfort when she first asked you, so she left it for that reason?

*V.G.:* And I was. I was very uncomfortable.

*Ther.:* If she felt it, she would have left it not to upset you.

*V.G.:* I always prepare myself when I speak to S. But the youngest one caught me the other day. S. was injecting herself when C. said, "All our lives we must suffer." I said to her, "What are you suffering from?" She said, "This bloody machine" (*referring to the pump*). I said, "Don't you bloody the machine. That machine is giving your sister a life." I cried the whole night. That is the way we need to live. You know, S. never asks me. She never questioned me about her illness.

*S.A.:* Even Z. does not ask.

*V.G.:* C. asked me how long S. will live. S. used to ask me a lot why the other two haven't got the same sickness. You know, there was a time I used to be concerned that S. is so quiet, but I got used to it. I never thought about it.

In the other group, our conversations also moved away from compliance and the desferil pump to more personal issues.

*D.T.:* They (*the group*) never knew any of my complaints while I was married. They never knew.

*N.Ch.:* She was still new in the group.

*D.T.:* I didn't talk to my parents either. For my parents everything is about duty.

*N.C.:* Mine is different. I have a stepfather and mother. I am never into confiding in them. My Mom may know, but I wouldn't tell her. I never give her worries, she has her problems.

*Ther.:* So how is talking here different to the way you relate to each other?

*D.T.:* Out from here we don't really talk to each other about private things. We may talk about children, or general things.

*Ther.:* How does it feel to share here?

*N.C.:* This is not the same. We don't talk just general. It is more personal and we open up.

Further in the same session the group spoke of their origins.

*D.T.:* My grandfather came here but my parents were both born in India.

*V.L.:* My dad turned 70 yesterday. I am third generation in South Africa.

*N.Ch.:* I am not Indian. My grandparents came from Java, Malaysia.

N.C.: I got stepfather. He was born in India 80 years ago. I never saw my father. Never. Never. My father and mother separated once she was pregnant, they were never together again.

Ther.: Do you know where he is?

N.C.: He passed away.

Ther.: You never met him?

N.C.: No. I never discussed it with my mother. She was 17 years old. My mother was born here, but I don't know about her background. She doesn't speak about that.

Exploring beliefs about gender, culture, and religion can make cultural discourses explicit and available for discussion (Coale, 1994). Through examination of these beliefs we expand on possibilities. David and Erickson (1990) highlight the role of ethnicity and ethnic heritage in psychotherapy. Ethnicity represents value systems and helps to structure and maintain patterns of interaction. These writers call for therapists to develop an attitude of openness to cultural variability and to the relativity of the therapist's own values.

Ther.: How do you see differences between ourselves?

N.Ch.: You people (*referring to therapist and her western culture*) maybe think differently. We must make sacrifices. You will say maybe that it is wrong to sacrifice, that we must fight. You think that way. But we were not brought up that way. You must not complain. It is out for you, it is life and sit with it. You are not going to think that way. You may tell us that it is wrong. We must fight.

N.C.: If you have problem with your husband you maybe will separate or divorce immediately. In our case it is wrong. But that has changed lately. If you used to mention word divorce it used to be a big thing. Now it changed.

Ther.: So what about D.T.? She divorced.

V.L.: This is why she didn't tell her parents until it blew up and that was when we found out.

Ther.: How does anything change in a community where beliefs are strict? Or it doesn't change?

*Everyone in the same voice*: New generations

Ther.: And do you belong to new or old generations?

N.Ch.: We are trying to be old. This new generation they go home and you hear next they divorced.

N.C.: I sometimes tell my parents I cannot stand this man (her husband). They say, "You are crazy. You got food in your house, what do you complain about?"

Ther.: And how do you, as a parent, see if your daughter feels that way?

N.C.: I don't want her to go through the same as I did.

Ther.: So there is a change then?

*V.L.:* It is the influence of the western world.

*D.T.:* But what position you are, at the end of the day it is for you to decide. Where and how you are going to fit and how much are you going to give up on your religion.

In one of the sessions, group members discussed how stressful their lives are.

*Ther.:* How do you look after yourselves?

*(Everybody laughs.)*

*N.Ch.:* We don't really look after ourselves. There is no time for that.

*N.C.:* You are busy all the time. You need to put the pot of food on the table. You know what I mean. Indian woman are like that.

*V.L.:* We do neglect ourselves. There is family to feed.

*D.T.:* You sacrifice for your child. I buy for M. (*her son*) and never mind for me if he needs it. But we are taken for granted. It is about woman growing up with that attitude – you are woman, you should know your place. But it comes to a stage where no one respects you.

*Ther.:* Are you talking about yourself?

*D.T.:* Ya. There is nobody for me.

Family therapists' interest in the cultural and social contexts of their clients is a recent development provoked, to a large extent, by feminist critiques. Consequently, says Coale (1994), the focus on family structure has shifted to "meaning-in-context". According to Coale, introducing beliefs from a culture other than the client's own can be useful in co-creating new meanings in therapy. Skinner (1989) points out that the direct expression of the therapist's values need not be a negative force. He proposes an approach where both the client and the therapist's values are constantly open to change and mutual growth through debate, where the final decision takes account of both sides of the argument.

*D.T.:* If you take over from your husband he gets comfortable and after some time he is totally uninvolved. But if they share it should make marriage stronger. But in Indian society they dump all responsibility on a woman.

*Ther.:* I think that in Western culture women have more freedom. But with more freedom comes more responsibility. These days women not only have a career but still carry all the other house duties and looking after the children.

*V.L.:* I saw a programme on TV that it is mother's responsibility to treat boys and girls the same. I think that will make a change. N. (*her son*) helps a lot at home.

*D.T.:* I give M. (*her son*) a lot of responsibility and tell him that it is not shame for boys to wash the dishes.

*V.L.:* When a man gets married and hasn't learnt to compromise it is a problem.

*Ther.:* Why are you (*to N.Ch.*) so quiet?

*N.Ch.:* My husband is completely opposite to what you are all discussing. He won't wash dishes, he won't move chair, he won't.

*V.L.:* Even mine.

*N.Ch.:* It is the way he was brought up. He was told: you are not *moffie* (*derogatory term for homosexual*).

*V.L.:* My husband never used to help. Now he is unemployed. I used to make beds and things, now I don't.

*Ther.:* There seems to be so many different ways of doing things.

*V.L.:* Well, I tell you, if his Mammy is around I will tell him and he won't do it. I had arranged marriage. I blame my parents...

*D.T.:* My father behaves like a king, "Get my shoes!" My brother says, "You get up yourself and do it." My mother says to him, "Do you think if I was educated I would be with you? I would of left you long ago."

*Ther.:* There seem to be no easy answers.

*D.T.:* I was expected to stay at home, look after the kids and house. But I changed my destination. I didn't dream of what is going to happen. When it (*marriage*) didn't work out I have to go out to find work. Now I am independent.

When we discussed the issue of responsibility for treatment of the illness, it seemed that the women carried most of the responsibilities for the child's treatment while the fathers stayed disengaged (Varekamp, Suurmeijer, Rosendaal, van Dijck, Brocker-Vriends & Briet, 1990).

*Ther.:* How do you deal with responsibility for the treatment?

*N.C.:* My husband never does the pump. I become used to it, but it used to bother me. My husband finds it difficult, but he doesn't show it.

*V.L.:* You get support from your family (*of origin*), not your husband. Most Indian families are like that.

*Ther.:* And how do you feel about that?

*V.L.:* I tried to fight it for 27 years. I tell him I am not a machine.

*D.T.:* My ex-husband never come to the hospital... he never took any interest.

*Ther.:* So you feel like all the responsibility is on you?

*V.L.:* If you know that you are not going to get any help from the husband – it is your entire duty – your child is in your hands – it is difficult.

With this entire responsibility on their shoulders, the women found it difficult to make space for rest and to look after themselves. Their cultural frame seemed to limit the exploration of other possibilities.

*Ther.:* How did you spend your holidays?

*V.L.:* I am so exhausted. I just want to sleep. We are not on holiday. Kids are on holiday. Twenty-four-hours wives do not get holiday.

*Ther.:* So when was your last holiday?

*(Silence.)*

*V.L.:* Few years.

*D.T.:* My last holiday was in 1985. More than 10 years ago.

*Ther.:* How do you manage?

*D.T.:* I am exhausted. I cannot function. I just go blank sometimes. I think of taking a holiday this year.

*Ther.:* It must be very hard. All that work, looking after the children, the thalassemia child as well...

*V.L.:* You must sacrifice to get something. That is what we were taught.

*Ther.:* So when you give, what do you get?

*V.L. (looking depressed):* We do give so much, but in return we get so little.

*D.T.:* Maybe we just hoping to get.

*Ther.:* What is it that you would like to get?

*V.L.:* Flowers. Attention.

*D.T.:* Love and spoiling.

In the children's groups, I discussed the communication pattern in the family. Coalitions in families with serious illness are dictated by the demands of the illness (Penn, 1983). When the child has a position that is closer to one of the parents, that indicates more distance between spouses (Herstein Gervasio, 1986).

*Ther.:* I was wondering about how you get on with your parents?

*R.C.:* When I am sick I want my Mammy.

*Ther.:* What about Dad?

*R.C.:* When I need money I go to him.

*N.L.:* Mommy gives you that extra support.

*R.C.:* I confide to my Mammy.

*N.C.:* My Dad works very hard. He comes late. He doesn't speak to me.

*Ther.:* Do you ever initiate conversations with your Dad?

*(Everybody laughs.)*

*Several voices:* No...

Similar family patterns emerged in the other children's group.

*Ther.:* How is Dad involved with your treatment?

*Z.A.:* He is not involved. My Mammy does everything.

*Ther.:* Why is that?

*K.A.:* It is easier to talk to Mammy. Mothers know how to talk. The fathers ... they watch TV. You cannot talk to them.

*Ther.:* Are you talking about your father?

*K.A.:* Yes. He says: "Ask your mother."

In respect of compliance, the results at the end of 1996 were very encouraging. All the children in the first and second groups were out of the alarming category of ferritin levels of 4000 or more, although not all had reached the ideal level of under 2500. However, the situation with the older patients was more complex. The doctors pointed out that once the ferritin level exceeds 10000, as it had with V.H., it does irreversible damage to the heart muscle even if the level goes down again, and it is just a question of time before the heart fails altogether. In 1992 Z.S.'s ferritin level was verging on 10000, which is the life-threatening category, but this level did, at least, go down to under 8000 in 1996.

Table 6.1

*Group I: Ferritin Levels*

<b>Patient</b>	<b>Ferritin level in 1992</b>	<b>Ferritin level in 1996</b>
N.L.	5352	1745
A.C.	6540	3900
R.C.	8450	3450
N.Ch.	5815	2534
N.C.	3387	1165
M.T.	1080	1082

Table 6.2

*Group II: Ferritin Levels*

<b>Patient</b>	<b>Ferritin level in 1992</b>	<b>Ferritin level in 1996</b>
S.G.	4671	3963
Z.A.	4712	2740
K.A.	4149	2895

I had been seeing V.H. regularly for the past year and a half, but had seen Z.S. and M.P. only occasionally. Even though their ferritin levels had improved, V.H. was living at the edge, and Z.S. was also close to the life-threatening category. However, M.P. was out of the alarming category.

Table 6.3

*Patients Seen Infrequently: Ferritin Levels*

<b>Patients</b>	<b>Ferritin levels in 1992</b>	<b>Ferritin levels in 1996</b>
V.H.	11500	10800
Z.S.	9748	7448
M.P.	4200	3400

In my individual sessions with V.H., his stories showed that his medically non-compliant behaviour could be viewed as a hidden suicide (Farberow, 1986). With many diseases, a patient's non-compliant behaviour may not have an immediate effect. The result may be slow and cumulative, while the patient may be in denial about the long-term effects – or may not care (Farberow, 1986).

*V.H.:* I suppose I can cheat doctors, but not myself. I stopped when L.R. died. It was in January 1993. Every January I count.

*Ther.:* What made you stop then?

*V.H.:* I wanted to do something stupid. I wanted to kick the bucket as well.

*Ther.:* Many are surprised that you are still around.

*V.H.:* At night they (*nursing sisters*) come and check: "He is not moving." Last night staff said: "You sleep so quietly."

*Ther.:* Are they scared you will die?

*V.H.:* At home as well. S. (*his sister*) told me she doesn't want to lose me. I was lying in bed and she shaken me to see if I am OK.

*Ther.:* So tell me about L.R.

*V.H.:* Last time he was looking very pale and in lots of pain when I came to the Clinic. I said his mother that he is not going to make it. I hold his hand and told him: "If you can hear me, squeeze my hand." He squeezed my hand. I said to him I will be there. And that was it. While I was holding his hand (*tearful*).

Hilton (1997a) warns that the therapist needs to be able to experience the feelings created in him by the patient without allowing them to trigger his own survival mechanisms. In order to do this, "the therapist needs to stay grounded to his own reality as an ordinary human being and as such act as a model for the patient" (p. 259). Hilton describes the therapist as a "resonating instrument upon which the music of the patient is played" (p. 259). This cannot, he says, take place unless the therapist has himself experienced such resonance and become aware of its healing effects, which would give the patient a more solid basis of safety for risking the exposure of his or her real self. As my sessions with V.H. continued, I started to disclose more about my feelings.

*V.H.:* It is nice to talk. I also think that you think, when you are at home, "How is V.H.?"

*Ther.:* I struggle at times. I am not sure what is (*becomes tearful*)... There are times when I feel...

*V.H. (interrupting):* Down?

*Ther.:* Yes. It is not easy. I get worried... and scared if I am going to see you next time.

Slow growth and delayed sexual secondary characteristics are just some of the results of iron overload (Georganda, 1988). As a result, body image, especially for adolescent and adult thalassemia patients, is a very painful issue (Georganda, 1990).

*V.H.:* I imagine myself when I go out of the bath and look at myself in the mirror. I wish that I was grown up, tall, have a nice chest, you know. Things like that... Out of thinking that way I start crying.

*Ther.:* Does it happen that people think you are younger than your age?

*V.H.:* Yes, all the time. I do get upset but I don't show it. I still didn't get used to it.

In August 1996 we spoke of the month's leave I would be taking from the hospital in September. Guy (1987) says that experiencing caring for and from patients is another meaningful encounter that makes for a deep and intimate level of relating.

*Ther.:* I mentioned to you last time I will be going away in September.

*V.H.:* It is going to be very empty without you. Are you going overseas to visit family?

*Ther.:* Yes. I haven't visited for some time. And how will you spend the time while I am away?

*V.H.:* I don't know what I am going to do. I will pass your office and say: "Zana left me and went... Couldn't she take me with?"

*Ther.:* Last time I spoke to you I was very... I kept thinking. Now when I go away I am going to worry if you will be around...

*V.H. (interrupting):* I will be around. Nobody will take me away. I am taking my heart tablets and I have been using the pump.

*Ther. (teasing):* Oh, do you still remember how to use it?

*V.H. (laughing):* Yes. I want to get used to it. Like before.

*Ther.:* While I am away would you like me to arrange that my colleague comes to talk to you?

*V.H.:* No. I feel safe talking to you. With other people it goes to the other world. I feel safe only with you. I will miss you.

*Ther.:* I will think of you.

*V.H.:* I have a strong faith. It will be OK. I will be around when you come back.

From the middle of 1996 more changes and personal shifts took place in one of the groups. One such shift occurred after V.G. revealed the secret of her history of

sexual abuse. The marital crisis set off by this subsequently led to separation and, finally, divorce.

*V.G.:* I want to tell you something I never told you before. I was very young (*crying*). It is for the first time that I can see how much anger I have in me. S. (*her husband*) and me were arguing and I just suddenly blurted it out. I was abused by my brother when I was very small and then when I was 13 years by my brother-in-law. He just married my sister a week earlier... (*sobbing*).

*Ther. (touching her hand):* You have told no one?

*V.G.:* I never told anyone. I don't know why it suddenly came out. It used to work on my mind whenever I had much to drink, before it would come back.

*Ther.:* How did S. react to that?

*V.G.:* He told his friend, and I asked him not to tell anybody. And I just cried. I told him I need separation to sort myself out. Then he said that if I don't go with him to see a marriage counsellor he is going to tell everybody. And I have been keeping it for so long because I didn't want my marriage to break up. If he tells my family... my father is so sickly and my mother would be very upset. I am totally disgusted with him. I feel he betrayed my trust. I will divorce him. I could kill him (*sobbing*). I don't want him to touch me. I thought I come to you and I make myself strong before he goes to tell everybody. I don't want to see a marriage counsellor. I wanted him to love me, to be jealous... but he was never there. It reminds me of my father, he was never really there. He worked nights and slept through day. I also blame myself... I feel dirty... I feel angry at myself and stupid for not talking about that. I was so scared that people would get hurt.

*Ther.:* What happened with your brother?

*V.G.:* At the beginning he just touched me but then later he did the whole thing. He used to make me feel like scum. Now with this crisis in my marriage, he also got involved and has been telling me what to do. My mother was shouting at me. I just want to die. I am 32 years, I never asked for help and now everybody is telling me that I am crazy and I need to see a psychiatrist.

*Ther.:* If he does disclose to your family would they question if it is the truth?

*V.G.:* I don't think my mother would. I cried so much yesterday. I think S. is so cheap. He is using anything to save the marriage (*crying*). I don't want to hurt anybody.

*S.A.:* What about the marriage counsellor?

*V.G.:* No. I feel comfortable with Zana.

*Ther.:* But it must be very difficult talking even to me about a secret you kept so long?

*V.G.:* Yes. It is about coming to terms with my past.

It was at that time that I acknowledged my own need to come to terms with my past. As Kramer (1980) says, "you can get yourself out of your family, but you cannot get your family out of yourself" (p. 297).

## *Personal Self*

My soul-searching opened up many painful and unresolved wounds. Goldberg (1986) argues that the “wounded healers” are thought to be best suited for the profession of psychotherapist because of the extent of their personal wounds. The psychotherapist is often regarded as the descendant of a line of healers and other ancestors that would include priests, witch doctors and family doctors.

The notion of the wounded healer relates closely to the use of self in therapy, and it may be a significant factor contributing to the healing of the patient. Miller and Baldwin (1987) suggest that the nature of the therapeutic relationship embodies the basic polarities inherent in the concept of the wounded healer. They point out that not only does the patient have a hidden inner healer, but that the healer also has a hidden inner patient, and patient and healer “cast mutual projections upon each other based on their hidden parts” (p. 142). The healer’s own vulnerability is activated by his contact with the patient, but if the healer can remain open and learn from the vulnerability created by the patient’s wound, then greater awareness and integration of his own wounds may be achieved. Miller and Baldwin believe that when the patient experiences true healing, it can produce healing within the wounded healer and in that case there is a mutual healing. Experiencing vulnerability results from conscious inner attention to one’s wounds provoked by the healer’s contact with the patient. Through the encounter with the vulnerable healer, the patient is able to achieve genuine understanding of the self. The wounded healer is also more likely to show greater empathy toward the patient. Miller and Baldwin (1987) emphasise the importance of vulnerability in the healing process and maintain that the healer becomes the receiver of healing by attending to his own vulnerability and dealing with the pain. Many healers tend to wear a protective mask and to keep patients at a distance, but this, say Miller and Baldwin, results in the denial and repression of their own vulnerability, which robs them of their energy and leads to burnout. The use of self as wounded healer in therapy can result in truly creative insights and remarkable personal growth.

Many of my conversations with the thalasseemics resonated with my issues: over-responsibility, inability to make space for my personal needs, coping with stress by working even harder, difficulty in acknowledging vulnerability and being

emotionally detached. Some of the discussions left me with reflections about several of my family of origin issues. When, in one of the sessions, N.C. spoke of never meeting her father, of his subsequent death and of her mother's difficulty in speaking about her past, I thought of her story for days afterwards. It made me question my cut-off relationships and my mother's secrecy about her past. I wanted to ask N.C. why she did not show more curiosity about her mother's past, but I did not, in fact, do so. Later it occurred to me that secrecy has infectious qualities that make everyone involved "join the club" by showing no curiosity or being sensitive to secrets and never asking. This was a familiar feeling from my family of origin.

Hilton (1997b) discusses the intimacy of the therapeutic relationship and emphasises that "while the therapist is helping the client deal with his fear of intimacy, he must also deal with his own" (p. 70). To make the intimacy of the therapeutic relationship less perilous for clients and therapists, the most important thing is for the therapist to take responsibility for understanding the nature of his role and how it functions in his self system. However, Hilton (1997a) also acknowledges that most therapists, including himself, have not taken the time to do this, and when the client challenges the therapist's role, they therefore respond defensively. Speaking of self-recovery for therapists, Hilton (1997c) points out that the first thing is to experience and not just acknowledge the fact that we, as therapists, have not escaped unharmed in our own families. Hilton concludes, "we became psychotherapists because we were broken and we thought this was a way to find healing" and, further, "our clients challenge our roles and give us the opportunity to once again recover our true expression just as we try to help them find theirs" (p. 157). He says he often tells his trainees: "Your clients and children will cure you, if you give them a chance" (p. 157).

My personal therapy provided some constructive ideas about my personal issues, but proved limited in terms of emotional insight. My first therapist was an example of the therapist as expert: emotionally neutral, knowledgeable and perfect. He personified the positivist paradigm where the therapist remains objective and in the "expert" role. For the first time, I really identified with clients of mine who got stuck because I was too scared to let go of the neutral, objective role. I often felt that my therapist's issues were interfering with our work, but my attempts to discuss this

were pushed back to me. My therapist did not take any responsibility for what I believe were some of his issues, and allowed no perception of himself as anything other than perfect. He remained detached and was careful not to disclose any personal information. This made me feel that he was more concerned with keeping his facade intact than with building a therapeutic relationship. In fact, there were times when I “protected” my therapist from myself because I could feel his discomfort when I was openly emotional. That was probably my main reason for discontinuing the process after a year. Before terminating, however, I decided to discuss my difficulties openly with him. Unfortunately, it seemed that his personal difficulties with his emotions prevented him from exploring the issues I raised, and he became defensive. As it seemed clear that the process could not improve, I did then terminate therapy.

In 1996 I started seeing a woman therapist, and experienced great emotional growth, especially in respect of my vulnerable self. Her acceptance of me helped me accept what I believed was my “weak” side – my vulnerability. My awareness of this vulnerability created more understanding, tolerance and empathy for my clients’ emotional struggles. For women therapists in personal therapy, seeing that their own therapist does not always behave perfectly is a significant experience, and the combination of competence and allowing doubts and vulnerability to be visible is an essential element in the modelling process (Coche, 1984).

Personal therapy made me more aware of counter-transference (Macran & Shapiro, 1998). My experience with the first therapist taught me that, in therapeutic relationships, I should place greater emphasis on the personal relationship with my client rather than on my theoretical orientation (Macran & Shapiro, 1998). Personal therapy reinforces a more realistic frame of personal and professional expectations and augments the development of personal and professional authenticity (Skovholt & Ronnestad, 1992). In attempting to determine interface issues within therapists’ professional and personal lives, Shadley (1987) discovered, unexpectedly, that personal transitions were more likely than other factors to induce therapeutic style changes, and to compel therapists into closer, more intimate contact with clients.

Our self is always defined in relation to others. During 1995, most of my focus was on my self, but gradually my relationships moved to the foreground. My

issue with over-responsibility, which went back to my family of origin, was also very present in my marriage. My marital discomfort was, at that time, very high, and this gave me the impetus to start working on the dynamics in my marriage as I felt I had little to lose.

### *My Marriage*

Most of us – and psychotherapists are included – have a dream that marriage is a happy state in which we will get the nurturance, caring and love that we did not receive in our family of origin (Napier & Whitaker, 1978). Once I had started creating mirrors for looking at my professional self, the process expanded to my personal life.

I agreed, in principle, that difficulties in the marital relationship are mutually contributed; but this was perhaps true only when I was referring to the patient system. I made it my business always to do things the right way, and I considered myself a responsible person. Most of my past approaches to marital difficulties were directed towards encouraging my husband to change. The good and the bad were defined as myself versus him. I was the responsible one, the smart one, the one that had guts and the one that did everything right. He was in the opposite corner – the irresponsible one, not so smart and not so courageous. Bowen (1976) explains that the lower the level of differentiation, the more intense the emotional fusion in the marriage. One spouse then becomes more dominant in decision making, while the other adapts to the situation. The dominant spouse gains self at the expense of the adaptive one, who loses self. This process had, perhaps, been in operation through most of our marriage up until then.

Every time my husband tried to do something different, I would get anxious and negative about his ideas. My criticism would make him doubt himself, his motivation would decrease and he would not do his best or he would give up. His failures would make me more worried about money, so I would work harder and criticise him for not being as responsible as I was. He made fewer and fewer efforts, and the efforts he did make failed, which was proof that I was right about his inadequacy. I see now how my worry and anxiety provoked self-doubt in the same way that his mother used to do, and at times my “preaching” (after all, I knew best)

was exactly like his father's "preaching". Being the responsible one was always my role and, much as I resented it, I confess I felt comfortable in that role – I was very competent at looking after others, and I had done it so well for most of my life.

We each reinforced the emotions and behaviours in the other that we objected to so much. As a result of the tension we were undergoing, my husband often suffered health problems, which would result in my taking even more responsibility, but at the same time my anger would be transformed into pity and trying to be nice. Bowen's (1976) concept of "dysfunction in one spouse" seems to fit very well with what was going on between us. In losing self, the adaptive spouse becomes less and less responsible as a result of the dominant one gaining self from the adaptive spouse, while the dominant spouse assumes more and more responsibility for the twosome. When the stress levels increase they trigger a dysfunction in the adaptive spouse, who has by now lost the ability to function and make decisions for him or herself. The most common dysfunction is physical or emotional illness or irresponsible behaviour.

Taking responsibility for someone else's growth inhibits the growth of the responsible one and creates the trap for him or her of "being so obligated to this mission that he/she cannot be his/her own relaxed self" (Charny, 1982, p. 44). I still remember times when I felt "bad" for having good news when my husband was down. I see, as well, how for years I kept looking at what was happening to him and forgot myself. I believe that this process placed so much pressure on him that it created stagnation rather than growth. In the meantime I was so busy trying to "fix" his life that I forgot myself and my growth also stagnated.

It was through my work with the thalasseemics that I was forced to acknowledge that I needed to shift the focus to myself. It was with surprise that I discovered how like my mother I had been, with my constant focus on everyone else's failures while remaining totally blind to my contribution towards maintaining at least some of the problems. Just as I had assumed that it was the thalassemia patients who had to change while I remained the same, so I had believed that it was only my husband who had to change. I began to let go of my need to take on every responsibility, and started enjoying having more time to relax and read instead of always doing something. My resentment began to melt, and we had more tolerance

for each other. Minimal criticism from me led to my husband's becoming more positive, and more caring and loving towards me. I was no longer a dragon.

### *Work on Family of Origin*

The signs of nascent improvement in my marital relationship gave me the courage to address a more difficult task: my family of origin. Work on the family of origin is believed to play an important role in the growth and development of the therapist's self (Bowen, 1978; Framo, 1979; Satir 1987). Most difficulties with client families can, according to Bowen (1978), be traced back to unresolved processes in the therapist's family of origin, which can result in inappropriate expectations and goals for the clinical families. The more intensity the family has experienced around certain issues, the greater the likelihood that individuals will react to similar issues in their personal lives (Meyer, 1987). Coche (1984) found that psychotherapists' family relationships were more stressful, more prone to difficulties in expression of affect, and experienced more intense adolescent independence struggles than was the case among other groups of professionals.

Guy (1987) found that psychotherapists often have mothers who are narcissistic and insecure, and whose emotional needs are the focus of the whole family. The fathers are often described as generally passive and non-intersecting (Guy, 1987). One may speculate that the choice of psychotherapy as a career could result from early emotional deprivation and that psychotherapeutic encounters may become a source of the closeness and intimacy that were lacking in the relationship with therapist's parents. Racusin et al. (1981) report that a very small number of the parents and siblings of psychotherapists were found ever to have undergone psychotherapy; we may therefore assume that the family's future psychotherapist was assigned that role at an early age (p. 271).

In 1996, I paid my first visit to Yugoslavia since emigrating, and since this gave me the opportunity to begin my work on my family of origin, I decided to start by dealing with the cut-offs about which I have already spoken.

Speaking of unresolved emotional attachment, Bowen (1978) concludes that the greater the amount of unresolved emotional attachment, the more intense the

mechanisms to deal with this. He refers to families where emotional equilibrium is achieved only with physical distance, where one member may run away, never to return, or to return only infrequently. He goes on to point out that the one who runs away deceives himself that he is independent, and actually “needs emotional closeness but is allergic to it” (p. 535). The more intense the cut-off, the greater the risk of repeating the same pattern in future relationships. Bowen also points out that people who cut off from their families are likely to create “substitute” families in their social relationships, which may provide a comfort zone until the relationships reach a certain intensity level, at which point they may follow the same pattern as family relationships. Our “cuddle group” at Coronation, to use Whitaker’s (1989) term, perhaps provided that kind of comfort zone for me. People who cut off emotionally from their families of origin tend to over-invest in current relationships, and the expectations of success in those relationship place added pressure on them, say Bray and Williamson (1987). These authors conclude that less differentiated individuals have difficulty in taking responsibility for their own actions and tend to blame others for what they themselves do.

As I have indicated, I had almost no knowledge about my father’s side of the family, and my information about my mother’s family was minimal. Meyer (1987) suggests that the lack of this kind of information, combined with the therapist’s expertise in interviewing others, may explain the tendency among therapists to interview rather than relate to their own family members. Meyer warns that such a strategy can easily end in failure. Thinking of my expectations of the visit I planned to make to my family, I realised that there could be substantial problems or even a failure to reconnect with some members. I decided, too, that I should be prepared to commit myself to making methodical efforts because a strategy of “hit and run” would, almost definitely, lead to failure (Meyer, 1987).

Meyer (1987) discusses four phases of defining the self in the family of origin. The first phase is marked by an intense level of anxiety in contemplating the attempt to connect with the family. The second phase is related to arrival within the family, whereupon the force of habit is strongly felt. The third phase is possible only if the second phase is successful; it results in a greater sense of self, provoked by creating a new functional and emotional position within the family system. In phase

four, after a period of exhilaration, many people report a period of emotional and physical exhaustion. However, Meyer points out that sometimes the therapist's efforts lead to failure and further emotional cut-off, an increased vulnerability to triangulation, increased anxiety and an increased likelihood of projection. She concludes that a therapist who has successfully defined the self in the family would be well acquainted with his emotionality and would be able to provide a maximum of thoughtfulness and a minimum of reactivity in the therapeutic process.

*My Mother and I: First Visit (1996)*

Throughout my childhood and adulthood I had mothered my mother. Therapists tend to be mediators and communicators, and generally over-function in their own families (Titelman, 1987). I decided that, during my first visit to my mother after emigrating from Yugoslavia, I would concentrate on taking a less responsible role with my mother, and that I would avoid being drawn into giving her advice. I made an effort to ask her opinion and to listen to what she had to say. I tried to tell her more about my vulnerable side, although she often minimised my feelings or told me that I should not feel that way. The other focus was our physical contact. Throughout my childhood, I struggled with feelings of discomfort about any physical contact with my mother. During this visit I attempted to be physically warmer towards her. To this she responded very well, which encouraged me to continue my efforts. I also noticed that she was less defensive and more honest about herself at those times when I made more physical gestures of love. This rewarded my efforts and motivated me to persist even when it was difficult.

My attempts at speaking to my mother about her first marriage and divorce, which had never been discussed, were mainly unsuccessful. Her initial responses to my questions were very defensive and uncommunicative. It was only during the second visit that we were able to move on a bit.

It is interesting that even though we had not seen each other for 4 years, my mother did not take any time off her work to be with me. We spent just the odd hour or two together at weekends, and she excused this by saying there was so much work and that "they" could not cope without her (this sounds so familiar). Even though the

business belongs to her, she could not make my visit a priority. Again, it was only during the second visit that this began to change.

*My Sister and I: First Visit (1996)*

A high percentage of family therapists, claims Titelman (1987), occupy the over-responsible, older sibling position in their families of origin. Before the cut-off between my sister and myself, I had an over-responsible role, as the older sibling, in my sister's life. For me it was about caring, and I never realised that for her, my over-responsibility was over-controlling. I saw her angry or resentful behaviour as, simply, ungrateful. The final break between us happened in 1989 after an argument, and resulted in a 10-year cut-off. I made several attempts to meet, but she refused to have any communication with me. She went so far as to refuse to open a goodbye letter delivered to her the day before I left Yugoslavia.

In 1993, my sister and my mother had an argument, which resulted in a 2-year cut-off. During this time my sister got married – there was no family member at the wedding – and had a baby girl. When her daughter was a year old, she resumed the relationship with our mother. I believe that my sister has struggled, for most of her life, with fusion. She was fused with me for most of her childhood, during our cut-off she was fused with her mother, and during the cut-off with her mother she became fused with her husband.

My professional struggle led to a self-analysis of my personal self and my relationships. Another view of these was taking shape and I began to see how damaging my behaviour had been for her; it had created a feeling of inadequacy and placed her in the victim role. I also started to face the realisation that the major force behind my over-responsible role was my need to be needed.

When my husband and I decided to visit our families in Yugoslavia, I wrote to my mother asking for her help in arranging a meeting my sister, who subsequently agreed to meet me at her home in the presence of other family members. This meeting with my sister was perhaps the most anxiety provoking of all. We had had a close relationship before the cut-off, and while this made me believe that we would

be able to connect again, I was also scared that any wrong comment or act on my part could lead to a permanent cut-off.

In order to explore the emotional issues with family members after years of distance, I needed to first establish a basic interest in my sister's general life, so that her level of reactivity would not become a major obstacle in defining our selves (Meyer, 1987). I was therefore content with a few meetings, always in the presence of other people. She kept her distance and showed no interest in my life or in me, but spoke readily enough about her marriage and motherhood. I met her husband and her baby for the first time. Her baby girl was then 6 months old. I think what was very important to her during those meetings was that she felt competent in relation to me. In fact, it was the first time that she was the "expert" because she knew about something I did not – motherhood.

I discussed with her my plan of finding a way of contacting our father and meeting him, together with her. She agreed with this plan and joined me for two of those meetings.



*Figure 6.1* With my mother and sister: 1996.

*My Father and I: First Visit (1996)*

It surprised me that it took me so long to admit to some truths about my relationship with my father. Through exploring my past with my therapist I had been able to see how my issue of control and inflexibility had its roots in my relationship with him. He had been in absolute control of me, and his unpredictable temper had provoked my constant fear and anxiety in his presence. I had promised myself never to let anyone ever make me feel like that – vulnerable – again. I therefore coped with fear of uncertainty by controlling my surroundings, by being inflexible and by never letting anything get out of hand. I can imagine that he became that way, too, by a similar process – his father having been an absolute tyrant who had no tolerance for any behaviour different from what he wanted.

After my parents' divorce and my father's subsequent immigration to Germany, I saw him only a few times from childhood until my twenties. Even the occasional attempts to reconnect were always made by me, not by my father. After each meeting, I was left feeling humiliated by him or my stepmother. The last time I had seen my father was in 1981, when I was 19 and had just started university. Fifteen years later I felt, for the first time, that I would be able to stand my ground and that I was no longer scared of him.

During my 1996 visit we met three times. First my sister and I met him at a restaurant in town. Next, he met the two of us and our husbands, and the third time I went to visit him at his home. I met his two adolescent sons for the first time, and had an opportunity to talk to my stepmother about the past.

In those few visits I discovered several secrets. I learnt from my father that his father had, by the time he retired, held a high position in the secret police. My father described his father as a psychopath who had a violent temper and physically abused his wife and two sons. My mother told me that my father had been absolutely petrified of his own father.

Another secret I was told by my father was that during her forties, his mother had been diagnosed as a paranoid schizophrenic. To me it seems like such a strange coincidence that she developed paranoia while living with a husband who was in the service of the secret police.

The most freeing feeling for me, during these visits, was my lack of fear; but it was also the first time that my father looked anxious. When he spoke to me he kept looking at the ground, and there was a meek quality to his body language. One of my intentions was to hear some of the stories about his family, but I managed to get only a minimal amount of information, mostly about his mother. During my visit to my father's home, he left for work and I spent a few hours with my stepmother. She surprised me with her honesty, and by sharing her life story, which I had not known. We were able to talk openly about old wounds and exchange forgiveness.



*Figure 6.2* With my father and sister: 1996.

## CHAPTER 6 (continued)

### **PART II: GREATER AWARENESS OF SELVES: 1997-2000**

#### Professional Self: 1997

The year of 1997 was in many ways a crucial year. Many changes occurred at Coronation Hospital. Renovations were finally completed and the thalasseemics moved to a permanent ward. The same year, after a very successful inspection and the excellent assessment received by Coronation's Psychology Department as a training institution, accreditation was granted for full-time training, and a junior psychologist was appointed. In February 1997 I registered at Unisa for the degree of Doctor of Literature and Philosophy in Psychology.

This was also a critical year in my work with the thalasseemics, and a most challenging year for my personal and professional selves. The ultimate challenge of death, and being there during V.H's month-long process of dying, brought the most profound learning for me.

Schaeff (1992) believes that the most trustworthy therapist is the one who knows, through personal experience, how to struggle back to health. She maintains that therapists must do the work on themselves that is necessary for them to move beyond the paradigm that keeps clients victims and therapists experts. As the therapist works on understanding and accepting her needs and healing her own wounds, she may be able to move to a paradigm where healing is really possible. One such paradigm is the participatory model in psychotherapy. Talking about the therapist's experience, Siegel and Lowe (1992) say, "In order to be honestly and genuinely empathetic, to relate on a deep emotional level, I have to reach into myself and search for real experience that resembles the one being offered for examination" (p. 193). Similarly, Demos (1993) holds that a clinician's ability to tolerate negative affect in her patient can be increased by fostering her own capacity for self-analysis, while Smith et al. (1990) suggest that instead of minimising the impact of the family system on the therapist, we should pay attention to our emotional experience with the family and use this experience in a creative way.

Langs (1997) describes death as a universal, pervasive danger situation that is unique among human threats. It is a background danger at all times, but at certain

points in a lifetime it becomes an acute danger. He says, further, that human reactions to this threat vary, depending on the activating trigger event: people may experience anxiety, depression, vulnerability, helplessness and a sense of loss, may behave in a way that reflects ambivalence towards a dying person or may be overcome with memories related to loss or vulnerability. Mental defences can, he says, be either (a) active, which means taking verbal or behavioural measures to deal actively with an emotionally charged event, or (b) avoidance coping efforts such as denial and repression. Langs comments that, since death knows no boundaries, it will affect both the professional and personal life of the therapist when she is confronted with death-related issues. He points out that lapses when working with these issues are inevitable but that the therapist should explore and work on her defences.

For Lendrum and Syme (1992), a clinician's ability to facilitate a client's process with grief is directly related to her self-awareness and self-reflexivity regarding her own process. As they point out, while helping a client to explore different aspects of loss, the intense feelings that the client cannot or dare not express may provoke feelings in the therapist that are difficult to bear and are perceived as threatening to the self of the therapist. Therefore, they argue, training in working with loss should be experiential since the therapist needs to come to terms with her own personal loss history and needs to re-experience her own grief. The therapist's capacity to tolerate intense feelings in her own self will, they believe, increase as she develops self-awareness and makes space for work on her personal self.

#### Thalassemics' Personal Stories: 1997

At the beginning of 1997, V.H. suffered a setback in his medical condition. During the next few months he twice suffered heart failure, and when everyone on the ward thought he would not wake up to see the next morning, he would pull out of it as if some invisible force was on his side. While his non-compliance provoked deterioration in his medical condition and neglect from his family, it also offered him a ticket for admission and the nurturance of a medical team (Cummings & Nehemkis, 1986).

*V.H.:* Honestly, when patients... when their parents come to visit I feel so down and lonely because no one cares to visit me. So I look at them and think

I should also be eating rice and curry, glass of cold drink. You know if my family could come and visit me tonight it would take my worries away.

*Ther.:* Have you spoken to your family on the phone?

*V.H.:* She (*his mother*) said, "Look after yourself, don't get hurt... cut yourself..."

*Ther.:* Was your mother worried that you might take your own life?

*V.H.:* She always thinks that way. The other day she thought that I was doing something funny. Like taking a rope and hanging myself.

*Ther.:* It sounds like it is becoming unbearable for you to wait any longer. Not knowing if you are dying. Were you thinking to take a short way out by yourself?

*V.H.:* I feel uncomfortable. This swelling is maybe showing me signs that I will kick the bucket.

*Ther.:* You haven't answered my question.

*V.H.:* I tried it once.

*Ther.:* When was that?

*V.H.:* Last week. But my friend come and stopped me.

*Ther.:* What did you do?

*V.H.:* I was to overdose myself on sleeping tablets and pain tablets. And I had a knife to cut my wrists. My friend called my mother. She said I am stupid... you cannot take life on your own. I just want to get over with it.

In the next session, our conversation became very emotional.

*Ther.:* You look scared.

*V.H.:* I am scared. I don't know what to do. It seems like for me... it is around the corner...

*Ther.:* To kick the bucket?

*V.H.:* I can feel it already. If I feel like this now... I don't know... (*He starts to cry for the first time; the therapist holds his hand.*)

*Ther.:* It is good to cry.

(*V.H. sobs.*)

V.H. survived his second heart failure and began to recover slowly. I contacted "Reach for a Dream", a foundation that has made it possible for many terminally ill children to enjoy a few last moments of happiness by making their dream come true. Although V.H., at the age of 20, was no longer a child, they agreed to help. He had never travelled out of Johannesburg and had never seen the ocean; so his wish was to visit Cape Town. "Reach for a Dream" flew him, his mother and sister to Cape Town, paying all the costs involved – the air tickets, hotel rooms, food and even pocket money. In the session after the trip, he looked very excited and spent most of the session describing his weekend down to the last detail. His mood was greatly improved.

*Ther.:* How are you feeling this week?

*V.H.:* I enjoyed myself so much. I am happy. It was nice week. I said to my mother, "When I come to the hospital Zana will want to hear everything. She encourages me." The only time I worry is the hospital time.

*Ther.:* That is today.

*V.H.:* Yes. But I came to talk to you. You are the only one I can trust.



*Figure 6.3* V.H. and the author at the beginning of 1997 (V.H.'s family have granted me permission to use the photograph for this dissertation).

In group sessions with the children, I asked them to write about how they saw their illness. Feelings of sadness, depression and anxiety are common emotions in thalassemia patients, but the desferil pump is viewed as a constant reminder of their illness (Georganda, 1988).

*Z.A.:* The things that scare me a lot are: What if my iron level rises and I die? Or going for blood transfusions. It is very painful, but I am getting used to it. My life depends on a small pump and without it I could die. I am very afraid of dying, especially at a young age. Many people around my age died of this illness and I hope I don't.

*N.C.:* I feel sad that I have illness and if I do not put the pump I might not lead a normal life. When someone in our group dies then I wonder if I am going to die in the same way and will I also suffer. This might sound stupid, but I feel special that God chose us from so many people.

*N.L.:* I feel that my illness is a God-given thing and there is nothing you can do, and the irritating part is the every night pump.

*S.G.:* I feel angry that there are so many people in the world and I was chosen to go through pain. I feel scared that something may happen to me.

*A.B.:* Thalassaemia is something that I had to learn to deal with. The most difficult thing about it was taking my pump every night. Thalassaemia had a benefit in its way, as I had lots of attention from my parents and I still do.

In March 1997 V.H. suffered his third heart failure. This time his medical condition worsened rapidly. A few days after admission he was in tremendous pain and so weak that he needed help with feeding and getting up. It was a difficult time for me, watching his struggle and pain. V.H.'s family did not visit him once during his 3 weeks of agony. I phoned numerous times, trying to persuade them to visit, but there was always a good reason for not showing up at the ward. I knew, however, that the death and dying of one of its member is a major disruption to a family. Some of the negative themes of a family grieving one of its members, reported by Maddi (1990), include guilt, resentment, relief from constant demands and a desire for an end to the pain even if this end is death.

V.H.'s whole body was failing him. Slowly all his organs stopped obeying him and fought against him. His own body became the enemy. He had hated his body even before this. The body had never been good to him, from the time this terrible illness came into his life when he was just 2 years old. His body did things he did not approve of. And it stayed tiny in spite of the years that went by – it looked like the body of a 12-year-old boy when in fact a man of 20 lived in it.

And finally this body gave notice to its owner, and no matter what he did, the body would not change the final decision. But V.H. would not let go so easily, and he tried to hang on to the fragment of life that was slowly crumbling. His stomach stopped digesting food, and from the seventh day in the hospital ward he was starving. He was taking only liquid so I kept bringing juices, those he said he liked, and I let him drink carefully. He was very weak after several days of starvation; his skin became very dry and tight as if it was going to break open at any moment. On the tenth day he was no longer able to pass urine. The colour of his skin changed to a light green – I had never seen such pain in someone's eyes.

I struggled with my fear of his dying and the unbearable pain I was witnessing, his needs, his tears. I tried hard to compose myself and look as if I was

fine, but there were so many times when the knot in my throat felt as if it would explode. I wondered what was he thinking, but I could not get myself to ask him. Instead, I spoke of stupid, unimportant things – pretending that everything was going to be fine. My awareness of the staff presence in the ward and my professional role kept me trapped in stiffened behaviour where my tears were quickly wiped off and there was no space to show any personal grief. What kind of beings are we, I wondered. Why are we so scared to show our real feelings for a fellow human being? I realised that my own need to put on the “professional hat” kept me safe and unharmed, untouched by powerful feelings that might otherwise tear at me inside.

Levy (1990) says that an experience in which the therapist feels helpless to alter the final outcome may provoke intense emotional reactions and create far-reaching consequences for her or his own life. Such an experience, he adds, presents a potential for profound learning in regard to the therapist’s own life, both as a professional and as a person.

One day, it crossed my mind that I was not behaving that differently from V.H.’s family. I was spending time with him, believing that I was making myself available to him, but the truth was that I feared any conversation about his real condition. I was scared of his questions and even more terrified that I might not be able to contain my grief if he spoke about his dying. Everyone in the ward – from the nurses to the doctors to myself – were pretending that he would be fine. I spoke to him about small, irrelevant things, and he was brave for me, protecting me from his questions and fears, both of us pretending – just like the family in Tolstoy’s (1981) story, *The Death of Ivan Ilyich*:

Ivan Ilyich suffered most of all from the lie, the lie which, for some reason, everyone accepted: that he was not dying but was simply ill, and that if he stayed calm and underwent treatment he could expect good results. Yet he knew that regardless of what was done, all he could expect was more agonising suffering and death. And he was tortured by this lie, tortured by the fact that they [his family] refused to acknowledge what he and everyone else knew, that they wanted to lie about his horrible condition and to force him to become a party to that lie ... He came within a hair’s breadth of shouting: “Stop your lying! You and I know that I’m dying, so at least stop lying.” But he never had the courage to do it. (p. 103)

The lump in my throat was growing. Skynner (1989) discusses the importance of the therapist's ability to tolerate uncomfortable feelings without escaping into defensive manoeuvres or intellectualisation. This requires a willingness to abandon feelings of identity based on the professional role and on the desire to "get somewhere" and to trust a deeper identity based on "being". Personal growth and professional growth are complementary cycles. Snyder (1995) talks of an approach of increasing empathic ability, which is often experienced as healing. Disidentification from one's own meaning systems, as being grounded in objective "truth," or as private to one's own experiencing, literally transforms the experience of self. The therapist, like the client, is almost invariably defended against certain emotions that can be painful or threatening in some way. These defences block the fullness of empathy and dialogue that effective therapy requires. By increasing the empathic presence, both client and therapist are simultaneously in the same experiential world, which brings considerable satisfaction in the process of sharing, so that there is less hurry or even the absence of the need to solve the problem or rectify the situation.

After consulting Ricky (my promoter, who often played the role of mentor and friend), I finally found the courage to let go of the "professional hat" and make myself emotionally available for V.H. I went back to his ward, and disclosed my emotional struggle. Searles (1979) surmises that when a therapist discloses her struggle, the therapeutic relationship can temporarily become reversed with the therapist exposing some of his or her own vulnerabilities to the client; but ultimately, the therapeutic endeavour is advanced. Skynner (1989) claims that one of the benefits of sharing counter-transference with clients lies in providing a model of tolerance for feelings. Palombo (1987) goes so far as to suggest that, even when anti-therapeutic, self-disclosures could have a therapeutic value in demonstrating the therapist's imperfection and humanity. She suggests, further, that self-disclosure may be part of the therapist's self-healing, and can serve to enhance the therapeutic alliance and further the therapeutic process.

As I told V.H. about my struggle, he began to talk. He spoke of his desperate need for his parents and how abandoned he felt. Levy (1990) reports that such feelings are not uncommon in dying patients, and that they generate distress and

depression. He adds that communication patterns within the family during the final phase are often complex, and feelings range from withdrawal and inadequacy to guilt. When V.H. spoke about the abandonment, he broke down and sobbed like a child. I hugged him and cried with him. The last thing on my mind, this time, was whether any of the nurses or doctors would see me crying and what they would think of me. I no longer cared.

Several days later V.H.'s condition worsen. He was extremely weak and unable to speak, and communicated with gestures. At one stage he took my hand and pulled it up to his chest; the nurse said that his body was hot and dry and gave me a soft, wet cloth. I sat next to him, his shirt pulled up to his neck, and slowly, softly massaged his weak body. He looked at me and I saw tears slowly running down his face. For hours I massaged his tiny body, both of us crying. He died 2 days later.

Those hours, when I sat on his bed and gently massaged his weak body, with no words being spoken yet with so powerful a connection between us, were healing for both of us. Touch is a controversial form of communication in psychotherapy and is often regarded as a damaging "tool" (Kertay & Reviere, 1993). Yet I learnt that touch can speak, in a better and safer way than words, about feelings – feelings for which we have no words.

V.H.'s family expressed their wish for Dr. G and me to attend his funeral, and we decided to share the loss with them (McDaniel et al., 1992). Attending his funeral was a way of saying good-bye and was, as McDaniel et al. predict, very healing. After coming to terms with my own fears, I was able to be really caring toward his family, instead of pretending. I felt a deep sadness about the unresolved feelings they were left with after his death. For 2 years after his death, his mother and sister kept in regular contact with me by telephone, and saw me on a few occasions. Most of their issues were related to their guilt about not being emotionally available to V.H. during his terminal phase. We spoke about this a good deal, and in time they seemed to come to terms with his death and forgave themselves for not being, respectively, the perfect parent and perfect sibling in that difficult time.

Duhl (1987) concludes that doing something different with oneself is the major component in changing self and context. Keeping a strict boundary within the therapeutic relationship might be a product of the therapist's discomfort rather than

of the patient's (Ramsdell & Ramsdell, 1993). Using oneself well means to be in a continuous project "to be curious about one's own reactions and intentions in varying contexts, and to locate the source of reactivity in one's learned-to-learn patterns" (Duhl, 1987, p. 75).

For many months after V.H.'s death the conversations in the thalassemia groups focused on death, grief and fear of death. Religion and spirituality were common ingredients of the stories, but when these topics entered the conversations I was confused about how to respond. I was born in a country that, for 30 years of my life, considered religion to be the work of the devil, so to speak. But it was for the sake of religion that so many atrocities were committed in my country during the civil war. Religion and spirituality did not form part of my training; they were the province of the priests. Indeed, Ross (1994) mentions that mental health professionals often hold negative stereotypes about religious practice and are very dismissive of both the power and the importance of patients' religious experiences.

The topic of death anxiety came up in one of my sessions with the children. According to Yalom (1980), parents in the Western culture are very much on their own when it comes to education about death. Other cultures, by contrast, offer some culturally sanctioned myths about death, which with no ambivalence or anxiety are transmitted to the child. Yalom notes that a positive sense of meaning in life is associated with deeply held religious beliefs.

*Z.A.:* I don't think of death. I avoid it. It makes me depressed.

*Ther.:* Are you always successful in keeping the thought away?

*Z.A.:* No. When someone dies then you think, "Who is going to be next?"

*Ther.:* Do you speak to anyone about that?

*Z.A.:* No. My Mommy would get depressed.

*Ther.:* So you think that she doesn't have the same thoughts you do?

*Z.A.:* No. I think she does. I think she thinks about that (*death*) all the time.

*S.G.:* You have to die. For us, in our religion (*Hinduism*), you get reborn.

*Ther. (to Z.A.):* And in yours?

*Z.A.:* You die and then there is a judgement day and you are asked if you did anything wrong and why. You may get punishment, but if you were good you will get to heaven.

*S.G.:* For us it is different. In this life you work out things that you committed in previous life. It is also about being nice to people.

In Hinduism, Karma represents the idea that what the individual does in this world affects what will happen to him in the next. Grief is expressed openly, and the thirteenth day after death marks the end of official mourning, after which men may shave, cut their hair and eat non-vegetarian food again. Hindu religious practice can vary enormously between different groups. Sikhism, which can be seen as an offshoot of Hinduism, believes that each soul goes through a cycle of birth and rebirth, aiming to reach perfection and be united with God. Among the Sikhs, a special ceremony that takes place after 10 days ends the official period of mourning (Lendrum & Syme, 1992).

The death of a loved one in Islam is seen as a temporary separation and part of God's will. Faith, prayer, fasting and pilgrimage are the duty of everyone within the Islamic community (Lendrum & Syme, 1992). Mourning usually lasts for 40 days, and during the first 3 days the family stays at home and their relatives and friends are duty-bound to visit them and bring food. Television and photographs are covered with cloth and throughout the 40 days indulging in any form of entertainment is not permitted.

The conversation reported above, and many others with the children and their mothers about the impact of religion on the meaning of their lives, made me aware of my ignorance about the place of religion in their lives. One of the mothers (S.A.) describes its role vividly: "It gives me courage. I don't think that without religion I would have courage to go through all I had to face".

I was now faced with my biases and prejudices about religion. Cecchin et al. (1994, p. 8) define prejudices as "all the sets of... ideas, accepted historical facts, accepted truths, hunches, biases, notions, hypotheses, models, theories, personal feelings, moods... in fact, any pre-existing thought that contributes to one's view, perceptions of, and actions in a therapeutic encounter." According to them, "just as one cannot not communicate, one cannot not have prejudice" (p. 29). Remaining curious about her self and her personal biases can promote the therapist's ability to openly address her prejudices. The term "curiosity" (Jones, 1988) was proposed by Cecchin in 1987. Curiosity relates to promoting as many alternatives as possible.

The term "irreverence" refers to a stance in which the therapist can believe strongly in a model or idea, yet discard it if it is no longer useful (Cecchin, Lane &

Ray, 1993). Irreverence involves examining one's own, often unconscious, assumptions or biases, and the irreverent therapist takes her own and others' beliefs seriously enough to question them when appropriate. Therapy occurs when the therapist's prejudices and those of the client interplay, and it is more useful to acknowledge them and examine them critically rather than deny or hide them (Cecchin et al., 1993). According to Ross (1994), stereotypes about religion can impose unnecessary limits on therapeutic work and prevent the development of the therapeutic alliance. Ross suggests that patients' religious and spiritual beliefs can be incorporated into therapeutic work, and that therapists should be willing to confront their prejudices about religion.

After the conversation in which Z.A. spoke of her reluctance to think of death and her difficulty in communicating with her mother, I decided to address the issue by using a personal example. Self-disclosure, according to Yalom (1980), is no less essential in group than in individual psychotherapy. Yalom points out that denial on the part of the therapist frequently silently colludes with that of the patients. He speaks of the group work he did with terminally ill people, and acknowledges that "only much later did we learn that we therapists had played an active role in keeping the group superficial" (p. 205). He goes on to say that when the therapists could tolerate their own anxiety and were not too frightened for the group to deal with death explicitly, then the group was able to confront the issues. However, the experience of working with the terminally ill was, he says, so painful at times that many of the therapists went for personal therapy, which proved very beneficial at that point. Yalom concludes that if the therapist is to help patients confront and incorporate death into life, she must be prepared to do personal work on these issues. To enter such work is, he believes, to heighten anxiety and discomfort. However, it is not possible to work on the issue of death without experiencing depression and anxiety for a period of time. Confronting a patient's death anxiety may also trigger death anxiety in the therapist. If the therapist is, by then, working on her own issues, she may experience the personal benefits of such work, but by incorporating these feelings in her work with the patient, she may have a greater ability to understand and help the patient (Yalom, 1980).

Lietaer (1993) emphasises the importance of congruence, saying that it requires the therapist to be sufficiently well integrated to be able to acknowledge his internal flaws and vulnerabilities. The therapist needs, as well, to be capable of accepting the positive and negative parts of himself without defensiveness. Congruence further implies honesty and openness, which parallel the use of self and self-disclosure.

Ruderman (1992) explores the benefit of the therapist sharing a struggle to resolve her own disturbances in the therapeutic relationship, and says this may deepen the connection between the therapist and the patient. When the therapist feels confused, frustrated or lacks resonance with the patient, she allows her internal images and dreams to flow freely and those feelings may feed back so that the patient will feel heard and understood. The added benefit to the therapist of working through her own internal experience, is continuing her own process of growth and development (Ruderman, 1992).

The following conversation was reconstructed from process notes:

*S.A.:* I was very upset last month. The transfusion day was just a day after V.H. died. We looked for you to talk. We were all upset.

*Ther.:* Yes. I am sorry that I wasn't there but I took a few days off. I was too upset to be of any use to anybody.

*S.A.:* I cannot stop thinking (*tearful*). It is like suddenly I think both of my girls are going to die... (*weeps; therapist moves closer and holds S.A.'s hand*). Was he scared?

*Ther.:* To tell you the truth, I think I was more scared. I think he made peace with it. I didn't know how to talk to him. I thought that I shouldn't upset him so I tried to pretend that everything was fine. I suppose I was scared. It looked like I was protecting him but I was protecting myself. I was terrified of his dying. It is difficult to talk about death...

*S.A.:* So what happened?

*Ther.:* I spoke to a friend who helped me to see that it was not for him but for me that I was pretending. After that conversation I decided to be brave and speak to him (*V.H.*) about my fears and struggle instead of pretending. And it was the best thing I ever did. He stopped protecting me and could tell me all. We cried together and shared so much. I am so content with the whole thing even though I miss him, but I know that at least at the end I was there for him (*weeping*).

(*S.A. sobs; silence for some time until she calms down.*)

*S.A.:* It reminds me of me.

*Ther.:* In what way?

S.A.: I cannot talk to them (*her two thalassemia daughters*).

Ther.: You mean you have the same problem I had?

S.A.: Yes (*weeping*). I am scared to talk about that. I don't want them to die.

Ther.: Of course you don't. And it is different with them. Their iron level has improved so nicely. They are far from dying. You all have so many things to look forward to.

S.A. (*smiling through tears*): I suppose that is true. But that is what makes me think I should just leave it.

Ther.: What do you mean?

S.A.: Talking about death. Now things are fine, so why upset them?

Ther.: Do you think they don't think of it?

S.A.: I was maybe wrong to think they don't. Maybe they do. Maybe they worry...

Ther.: So what would they do with all those worries and questions?

S.A.: That is my worry. Maybe they cannot talk to me because they worry about me, and maybe I don't talk to them because I worry about them. Sounds crazy, ay?

Ther.: No, not at all. I think that is exactly what is going on.

S.A.: I think the same is happening between me and R. (*her husband*). We are both thinking the same, but we are not talking in fear to upset each other.

Ther.: Well, perhaps after you give it some thought you may come to a more useful strategy.

S.A.: This was very helpful to me.

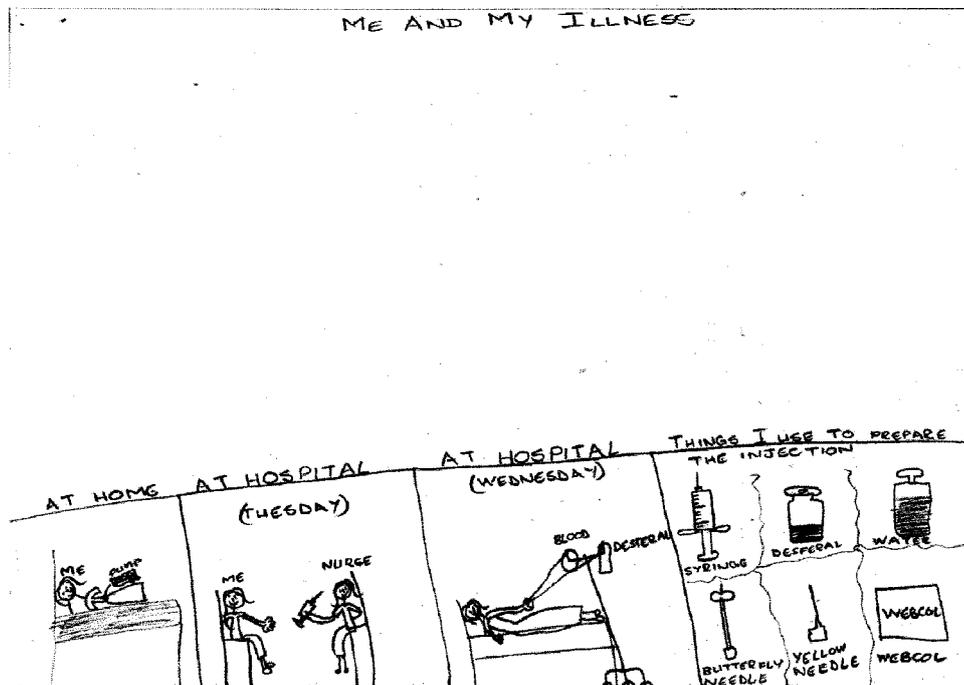


Figure 6.4 Drawing: Me and my illness.

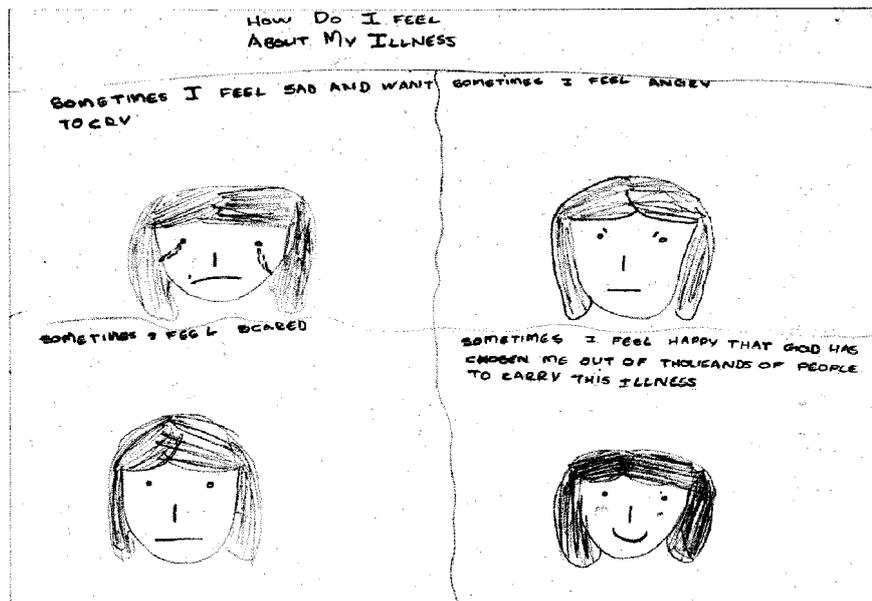


Figure 6.5 Drawing: How do I feel about my illness.

WHY DO I FEEL SAD AND WANT TO CRY  
 When I think about the illness and the injections I have to get, I feel sad

---

WHY DO I FEEL ANGRY  
 I think that ~~there~~ <sup>there</sup> are so many people in the world and I was chosen to go through pain

---

WHY DO I FEEL SCARED  
 I am scared that something may happen to me

---

WHY DO I FEEL HAPPY  
 I feel happy because I get a lot of attention and things that I want

Figure 6.6 Drawing: How do I feel about my illness.

When change takes time, the therapist may push for more insight or lose patience. One of the expectations that therapists may have, says Yalom (1980), is that change will result when the patient becomes aware of what is truly good. This approach may generate some stirring in a patient, he adds, but it may be insufficient for sustained movement, and the therapist should rather prepare for long, hard work. Through the last 3 years of working with the thalasseemics I, too, learnt that change takes time.

I had previously noticed a very destructive pattern: every time one of the thalasseemics died, the whole group was shaken, lost hope, stopped using the desferil pump, and as a result their ferritin levels were badly affected. But to my surprise, instead of the usual pattern after V.H. died at the end of 1997, the children's ferritin levels showed even further improvement.

A conversation with one of the children's groups suggested that, in spite V.H.'s death, they were able to remain positive about the future. R.C. described how her will changed from "counter will", or opposition to another's will, to "positive will", or willing what one must. Finally she developed a creative will, or willing what one wants (Yalom, 1980). The will is intimately bound to the future; it is through the will that we project ourselves into the future, and the wish is the beginning of that process. Wishing gives content to the will, while willing gives self-direction to the wish (Yalom, 1980). When a patient has greater access to his affect, he also has greater access to his wishes and his will. Once an individual has fully experienced his wish, he is faced with a choice or a decision, which is the bridge between wishing and acting.

*R.C.:* I do think of death. When anyone in the neighbourhood dies, it makes me think. When V.H. died, you think if you the next one.

*Ther.:* And how do you answer that question?

*R.C.:* I don't think so. It is just sometimes you get upset.

*Ther.:* Do you speak to your parents?

*R.C.:* If you try to talk to them they just tell you: "Put your pump and you will be fine."

*Ther.:* So you put it to make them happy?

*R.C.:* I did used to fight them when I was small. I was too young to understand. When I was bigger I could understand that it is for my own good.

*Ther. (speaking to everyone):* Last year R.C. told me that she believes that she will not live to 21 years. Do you remember (*to R.C.*)?

*R.C. (laughing):* Yes. I don't think like that any more. I am using the pump because I want to live. I want to get married and go to Mauritius for a honeymoon.

*Ther.:* I like your dream.

*N.C.:* I would first like to study. I want to be a doctor.

Several months after V.H.'s death, patients and parents spoke of their long journey and their difficulties on that road. They said that so few people know or understand what thalassemia is about, and they decided to approach certain radio and TV stations and negotiate a programme on thalassemia major.

Radio and TV show host, Patricia Glen, took a great interest in this suggestion, and decided to do both a radio and a TV show on thalassemia major. The show featured interviews with thalassemia children and parents about their experience of the illness and about patients' deaths in the past. Dr. G. and I talked about the medical and psychological implications of the illness, about non-compliance and about our approach to improving compliance. The decision to approach radio and TV stations in an effort to educate others about thalassemia constitutes what Taylor and Aspinwall (1990) would call a positive strategy in coping with illness. These authors identify a number of positive coping strategies, such as seeking out support, direct problem-solving, and finding meaning by focusing on positive aspects. They refer, as well, to negative strategies, including cognitive avoidance or denial, characterised by the avoidance of stressful thoughts and emotional distancing or detaching oneself from the stressful event.

*D.T.:* I have nobody to talk to. This is the only place. I tell you I am scared that I am going down. I am getting tired. It is like standing at the edge and just one thing can make you collapse.

*N.Ch.:* I am a very strong person. But I also got problems. My husband is not my family, he is not part of me. I won't put my hopes in him.

*Ther.:* It sounds like you distanced yourself by being strong?

*N.Ch.:* A lot. Even from N. (*her thalassaemic daughter*) – I won't come close. It is better that way.

*Ther.:* People are different. I can relate to what you describe. I suppose we all do it sometimes when we feel it is too much.

*N.Ch.:* I am trying to make myself strong. There are days when this thing comes back and makes me feel down but I tell myself to forget it and try to stay positive.

*Ther.:* What is it that is so difficult to forget?

*N.Ch.:* When our child died at 6 in car accident. That was the worst for me. It was in 1992 (*tearful*).

*Ther.:* God... I never knew... you never spoke about it.

*N.Ch.:* Well, you must distance yourself otherwise you get crazy. My friend said to me that one day I am going to have a nervous breakdown because I don't talk. But I am strong. I must be there for my kids. But I don't get close to N., that is how I can stay strong.

*Ther.:* I am wondering what you were referring to when you spoke about husband not being your family?

*N.Ch.:* He used to be so close to his family. Whatever they say he would do. You know our Indian man listens only to his mother.

*V.L.:* Indian women are born to be slaves.

*N.Ch.:* I never got on with his parents, but one day my father-in-law was very rude to me, and my husband just kept quiet. I told him to leave the house and I never want to see him again. He turned to my husband and asked him what he will do. I said to my husband that this time he will listen to me otherwise he may leave the house as well.

*N.C.:* I never knew that.

*N.Ch.:* I never spoke to my father-in-law. Well, only last year when he was dying, he kept asking for me so I went. I hate hypocrisy. I didn't want to go. But everyone said I should. He said he is sorry. He was crying. I said it is fine. I went to his funeral.

*Ther.:* After I heard your stories today I can understand your behaviour. I must be honest – I often thought that you are so hard, and like you have no heart. But now I understand very well why you look like that. You needed to protect yourself.

*N.Ch.:* I distanced myself. It was the best I could do... (*weeping*).

*D.T.:* One learns hard way. I also grow harder. When I remember the way I used to be – shy and withdrawn. But the worst was through my divorce. But now when I look back, I learnt so much and discovered so much about myself and what I can achieve.

*N.C.:* I take one day at a time. The last 2 years were very difficult with my husband and what happened (*referring to his affair, which she had disclosed in the group*). I think I will get better.

After V.H. died, I learnt to respect religion and its role in people's lives. It became a common theme in the groups.

*Ther.:* What helps to accept it (*illness*)?

*N.C.:* You pray.

*V.L.:* You pray to get strength to get along.

*D.T.:* In our temples they say that whatever happens to us, it happens for a reason. The priest once told me a story. You are a mother. What mothers do when they keep children away? They give them toys and things to keep them busy away. But when mother wants her child close to her, she embraces him.

God does the same when he wants you close to him. He doesn't give you wealth and material things so he can keep you away from him, but he gives you illness and suffering to get you close. When we are OK, we never think of him, but it is when you have sadness in your life that you look up to God.

*Ther.:* That is an amazing story. In fact the kids have often said to me that they have been given this illness because God wants them close to him. Now I know where it comes from.

*D.T.:* Yes. That is what we believe in our religion.

#### Professional Self: 1998

Turning now to the hospital context, 1998 was a very exciting year. The full-time training of clinical interns began that January. Work on the family of origin was introduced through training in family therapy using a one-way mirror. We used genogram work, which allowed us to visualise intergenerational patterns in relationships (Bowen, 1978). However, examining and dealing with the dynamics of one's own family of origin is more than just an academic exercise. It is a demanding process, which can facilitate more effective clinical work and added inventiveness and creativity when working with clients (Anderson, 1987). I hoped that, through this training, the interns would gain an adequate understanding of family of origin work, and a knowledge of selected techniques. There was also personal work by the trainees, dealing with important issues in their own families of origin (Anderson, 1987). The course had a didactic and an experiential part, but the issue of trust and willingness to do the work was crucial (Anderson, 1987).

Regular supervision took many hours of my available time, which forced me to look at my own issue of over-responsibility. I learnt to delegate responsibility, and having a colleague and so many interns made it possible. The interns took part in regular paediatric meetings and gave presentations on cases and points of theory every 2 weeks. Such close collaboration between the psychology and the paediatric departments greatly benefited both sides. We learnt about the biomedical model, and this enabled us to take a more holistic approach to the patient, where the body is as much part of the conversation as the emotions or cognition (McDaniel et al., 1992). The medical staff learnt about appropriate referrals, and about psychological models and language. Our discussions enhanced their competence in dealing with the

complexity of compliance and increased their resources by providing them with useful approaches to the emotional side of their job (Seaburn et al., 1993).

That year I was accepted for a 2-week training programme for foreign therapists at the Institute for Family Therapy in Rome, led by Maurizio Andolfi. This practicum, as Andolfi prefers to call it, addressed professional handicaps through discussion and experiential exercises in a small group of therapists.

#### Thalasseemics' Personal Stories: 1998-2000

Many shifts became apparent during this period. I shared my struggle with V.H. with the thalassemic groups, and told them how the process had changed dramatically while V.H. was dying. My story and my honesty helped V.G. see the destructive force of the secret about her daughter's HIV status, and S.G. was finally told about it. The most unnerving fact was that S.G. had known about it all along, but because she sensed her parents' fear she kept silent to protect them. She told me that she had overheard the doctors talking about her HIV status several years before. She knew from TV and talks at school what HIV was but she did not tell anybody for fear of how they would react. This meant that she never had the space to talk about her own worries and fears, or to ask any questions. This probably explains her withdrawn behaviour and the depressed affect that I had observed over the years. At the time of writing, S.G. receives a free supply of the AZT drug, which has made a great difference. Her compliance with regard to using the desferil pump has been very good. Talking about the change in her communication with her mother, she said: "We use to be like that... you know... like not talking. But it changed, now we can talk about anything, after that time you spoke to Mammy and then she spoke to me... It is different... We are not scared any more." Her mother, V.G., divorced the husband, got married a year later and had a healthy baby boy last year. S.G. and her two sisters are at present with their father, who also remarried and had a healthy baby girl this year.

S.A. was in the same group of mothers as V.G. She told her two daughters, who were attending the same children's group as S.G., about S.G.'s HIV status. I had several sessions in the second children's group during which we discussed their questions and concerns. All of them are doing well at present.

S.A. described her healing and transformation as follows:

We came to terms with illness... and what was going on. Before I couldn't never talk about it, but now it is much easier... I have much more hope. We used to think, who is next one to die, but now I don't think that way anymore. I changed. I used to keep quiet but then came a time I had enough. I said what I had to say... They cannot take advantage of me, funny that now they seem to have more respect for me than when I was so polite and quiet.

In the other children's group we had the most exciting event for the whole thalassemia "community" when one of the thalassemia girls (R.C.) got married. In 1996 she spoke of her hope of getting married one day, and her dream came true in April 1999. Her wedding strengthened everyone's will and hope to see the same thing happen to them. It is unclear whether she may be infertile due to the damage done to her body between 1990 and 1994, when her ferritin level was over 8000. At present R.C. is undergoing various tests and procedures, which we all hope will result in another miracle – a baby. N.L. is doing well and is working as an assistant in a pharmacy. A.C., N.Ch. and N.C. are all studying and doing well. M.T. is attending primary school and coping extremely well. The other exciting news came at the end of 1999 when everyone's ferritin levels finally reached the ideal level of less than 2500.

Table 6.4  
*Group I: Ferritin Levels*

Patient	Ferritin level in 1992	Ferritin level in 1996	Ferritin level in 1999
N.L.	5353	1745	1110
A.C.	6540	3900	2223
R.C.	8450	3450	2168
N.Ch.	5815	2534	2168
N.C.	3387	1165	1076
M.T.	1082	1080	613

Table 6.5  
*Group II: Ferritin Levels*

Patient	Ferritin level in 1992	Ferritin level in 1996	Ferritin level in 1999
S.G.	4671	3963	2079
Z.A.	4712	2740	2200
K.A.	4149	2895	2460

In the second group of mothers D.T., speaking of the children's change in attitude, said: "They had attitude: 'We going to die soon, so who cares', but they changed. They see the future now. They want to live. They don't want to die."

The following stories confirm Gerber's point (1986) that, when dealing with compliance problems, the therapist should expand the focus of the dialogue to other issues that are not directly related to the illness. This process, according to him, helps maintain emotional equilibrium, which is a significant motivational aspect in compliance.

D.T. said: "We got to speak about other things that are important, not just illness and pump – when those other things were sorted out then you can cope better". V.H., speaking of change, said: "It (therapy) helped the children a lot. It built their confidence but it is our attitude also, we got more positive." N.C., speaking of her husband's gambling problem and their crisis about his love affair said: "Gambling stopped. I feel everything was for the best (referring to their marital crisis). It got us much closer." About her daughter, who got married, she added: "R. used to think she would die before 21. But she changed. She has hope now – and for me to see her getting married was a miracle".

The two older thalassemia patients, Z.S. and M.P., are doing well. M.P. got married in 1998, has completed a computer course and is working. Z.S.'s ferritin level dropped from 7448 in 1996 to 6187 in 1999, which suggests that he is using the pump. He gave me a short poem, which he wrote some time after V.H.'s death:

Yesterday is gone,  
tomorrow you might not see,  
but today is here –  
so make today a happy place  
to live.



*Figure 6.7* Christmas Party: Thalassemia children at Zoo-lake in 1999 (all the families have granted me permission to use the photograph for this dissertation).

#### Professional Self: 1999-2000

At the present stage of my professional development, the ability to use my integrated self in a more effective way is the most significant shift. The idiosyncratic nature of this process may explain my difficulties in saying what exactly I do in therapy (Skovholt & Ronnestad, 1992). I no longer experience my personal life and crises as negative forces, but see them as enriching and increasing my ability to use my self in a beneficial way for my clients. This evolution of the personal and professional selves needs a life-long commitment in which the “wounded healer”, by healing her own wounds, increases her ability to facilitate her clients’ healing. Also at this stage, according to Skovholt and Ronnestad (1992), one’s own personal life provides an intensely important influence. Therapeutic relationships have a deep and central role, and there is less focus on techniques, while the techniques that are used are much more personalised. There is more understanding of the limitations of techniques and much greater confidence in the use of self (Skovholt & Ronnestad, 1992). Satisfaction comes from being more effective with difficult and challenging clients.

There were many times, during the 6 years of my employment at Coronation Hospital, that I was negatively perturbed by strikes, the chronic demotivation of the staff, over-responsibility, and lack of a support system. When I considered the

possibility of resigning, I was confronted with the fact that there was no one else to take over. This would mean that all the work and effort to build a department and get training accreditation would go nowhere. But from 1998, with the expansion of posts and the presence of interns, I was able, for the first time, to feel hopeful that things would function without my presence. Thus, at the end of 1999, I resigned from my position at the hospital. I still see the thalassaemic parents and children, but less frequently than when I was employed at the hospital. All of them are doing very well. I am glad to see that Coronation's psychology department remains functional and I hope it will stay that way. I have continued with my private practice while completing the doctorate.

In June 2000 I presented a workshop at the World Family Therapy Congress in Oslo. The theme of the workshop was related to the connections between professional competence and issues stemming from the family of origin. On my way to Oslo I paid a visit to Holland, where I met with three Dutch colleagues whom I got to know in Rome at the Andolfi practicum. We continued the work on our "handicaps", and our process once again confirmed the importance of a continuing focus on the therapist's self in order to avoid the destructive effects of the handicapped personal self on the professional self. My struggle and the subsequent shifts in my professional and personal selves suggest that optimal professional development is a long and slow process. Thinking of the future and of the next stage of development of the professional self, it is very soothing to read that reaching the integrity stage leads to "profound acceptance of oneself as therapist and profound endorsement of oneself as a therapist" (Skovholt & Ronnestad, 1992).

#### Personal Self: 1997 to the Present

After V.H. died, I initially felt numbness and disbelief. A month later this was replaced with feelings of anger and bitterness, until finally, over the next few months, I came to acceptance and relief (Lendrum & Syme, 1992). I had not realised, before, that death could add a dimension to the meaning of my life. Yalom (1980) holds that meaning refers to making sense and is never obtained from studying component parts. When we live our life without any thoughts of death, life loses its intensity and we live our inauthentic self that becomes forgetfulness of being

(Yalom, 1980). V.H.'s death stimulated my personal growth through inner changes like those mentioned by Yalom: a rearrangement of life priorities, a sense of liberation to do things I chose to do, an enhanced sense of living in the immediate presence, deeper communication with loved ones, and a greater willingness to take risks. Yalom describes numerous instances where confrontation with death has led to a turning point in someone's life. "Recognition of death contributes a sense of poignancy to life, provides a radical shift of life perspective" (1980, p. 40). As death makes us aware of the impossibility of further possibilities, he says, it reminds us that existence cannot be postponed. The loss of someone we cared for brings us in touch with our own vulnerability (Yalom, 1980).

In 1998 my emotional struggle continued, but my motivation to improve was even stronger. My marital relationship was bringing greater satisfaction and intimacy. I kept in regular phone contact with my family, and in 1998, after attending the practicum in Rome, I made a second visit to them.

*My mother and I: Second Visit (1998)*

I learnt long ago that the past is mostly something no one liked talking about in my family, and I generally respected that reluctance. At the practicum in Rome, however, the group analysis of one of the families I presented led me to discover that my exaggerated respect for secrecy within my family of origin blocked me in exploring the secrets in the client family. This discovery strengthened my motivation to persist with the issue of secrecy. After the practicum, I thought that almost 30 years after my parents' divorce it was time to open that "secret file".

My mother took a week off and paid for the two of us to take a holiday at the coast. It was the first time we had spent alone and together in years, and although it was not an easy time it was immensely healing. She was very emotional at times and I gave her support, but I was careful not to allow myself once again to play the role of mother to her. Instead, I brought up some of my difficulties and asked for her opinion and help. One of the things I said was that it would help me a lot if she could tell me more about the past, as I had no memory of my childhood. Perhaps my approach was different, or the timing was better, but this time she was not defensive. We managed, on a few occasions, to talk about her past, and her understanding of her

family and marriage. I found myself feeling love and tenderness for her, which I had never felt before. It was delightful for me not to prescribe hugs but just spontaneously to give and receive them.

*My sister and I: Second Visit (1998)*

During my second visit, my sister invited me to stay over at her house for a weekend. We had several hours alone and we spent most of this time talking about relationships in our family. Although I promised myself that I would not fall back into the pattern of creating triangles in respect of my sister and me against my mother, I found myself doing just that. Now I see that trying to connect meant doing the only thing we knew, our old pattern – triangulation. Bowen (1978) defines triangulation as a process that typically occurs between two people who are unable to address the anxiety in their relationship and channel it towards the third, triangulated person.

I used a few occasions when we were alone to find out more about her life and motherhood. I noticed how important it was for her that she could tell me about motherhood even though she was the younger one. I observed our conversations and meetings with careful attention to each detail and each word spoken in my effort to understand and learn more about her. I realised that I had never known her real self, and that she had, perhaps, often felt threatened by me and had, as a result, gone “into hiding”. I saw how sensitive and vulnerable she felt with me, and what upset me most was how inadequate and worthless she experienced herself as being, compared to me. This helped me understand her decision to cut off from me: she had probably not felt strong enough to “put me in my place”. During the first visit I could feel her hatred and anger, but she would not talk about it. During my second visit, she made some comments along those lines, which I received and listened to without defending myself. This seemed to give her a bit more confidence and the motivation to “deal with me”.

new deaths and worrying about whether she would ever see us again. It was a very difficult time for all of us.

My sister decided to remain in South Africa for a while, or at least until things changed at home. I organised a flat and furniture for her, but the atmosphere began to change. I began to feel burdened by her stay and caught up in the old web – taking responsibility for her and being the mother. We eventually came to a point where we were having angry arguments with one another. I felt relieved to be able to be angry openly with her and even shout and be shouted at. It was a very new experience for the two of us – to disagree yet maintain our relationship. After 3 months in South Africa, she returned to Yugoslavia.

A surpassing result of this crisis was that it allowed more openness and honesty about our feelings and behaviours. In the past year both of us have been making efforts to improve our relationship. I have the feeling that she shows more interest in my life, and more caring for me, which gives me hope that something is changing.

#### *Mother's Visit: 2000*

At the beginning of 2000 my mother made her first visit to me here, 8 years after my immigration to South Africa. The visit was prompted by a discussion about whose turn it was to visit, when she said: "You are younger and it is easier for you to come here." Previously, when she had made similar remarks, I had been very angry and disappointed, but had never voiced it. This time, I said: "What kind of love is it when you only love when it is easy? For me, real love is when one makes an effort even when it is not easy." There was silence on the other end of the line, and I became very anxious that she might not speak to me again.

She phoned me several hours later to say that she had never seen it that way. She agreed to come, and immediately began making arrangements for the trip. My husband went to visit his family while my mother was here, so she and I spent 3 weeks alone, without interruptions from other family members or friends.

It was an intense and emotional episode in our lives, with several issues coming to the fore. We spoke of patterns and similarities between us, and of patterns

that were repeated throughout the family. We had several arguments and disagreements, which we resolved by talking. An event that I found both fortunate and unfortunate was an attempted break-in at my home while we were asleep. I suffered anxiety attacks for a month afterwards. Her initial response was much the same, with little space for my vulnerability, but I became upset with her response and told her how it made me feel. This led to a conversation about the meaning of being “strong”, and patterns in the family around responsibility and strong females. She responded emotionally to my story and told me some family stories I had not heard before, which clearly pointed to the recurrence of the same pattern from at least the time of my grandmother and her mother, then with my mother and her mother, and now with my mother and me.

In one of her latest letters, my mother told me that as a result of that emotional conversation she began to see her own mother in a more loving way, and has been able to spend more quality time with her since returning to Yugoslavia. I still have times when I struggle with my feelings for my mother, but experiencing a real tenderness and love for my mother has even changed the quality of the negative feelings. The differentiated person is the one who has achieved a position of being real, of being free to be oneself in one’s family of origin, with both negative and positive characteristics, and feeling unthreatened by the other’s reality (St. John, 1987). My mother wrote, in her letter of May this year: “I am aware that our relationship is still vulnerable, but I feel very positive that we will achieve a more desirable relationship where both of us can be who we are without feeling that we are a threat to one another.”

My process of differentiation and becoming real in respect of my personal self has brought greater competence to my professional self. My professional development has moved towards the individuation stage, which involves a higher order of integration of the professional and personal selves (Skovholt & Ronnestad, 1992). The process I have been through, of understanding the complexities and connections between the professional and personal selves, has led to a greater integration between the two.

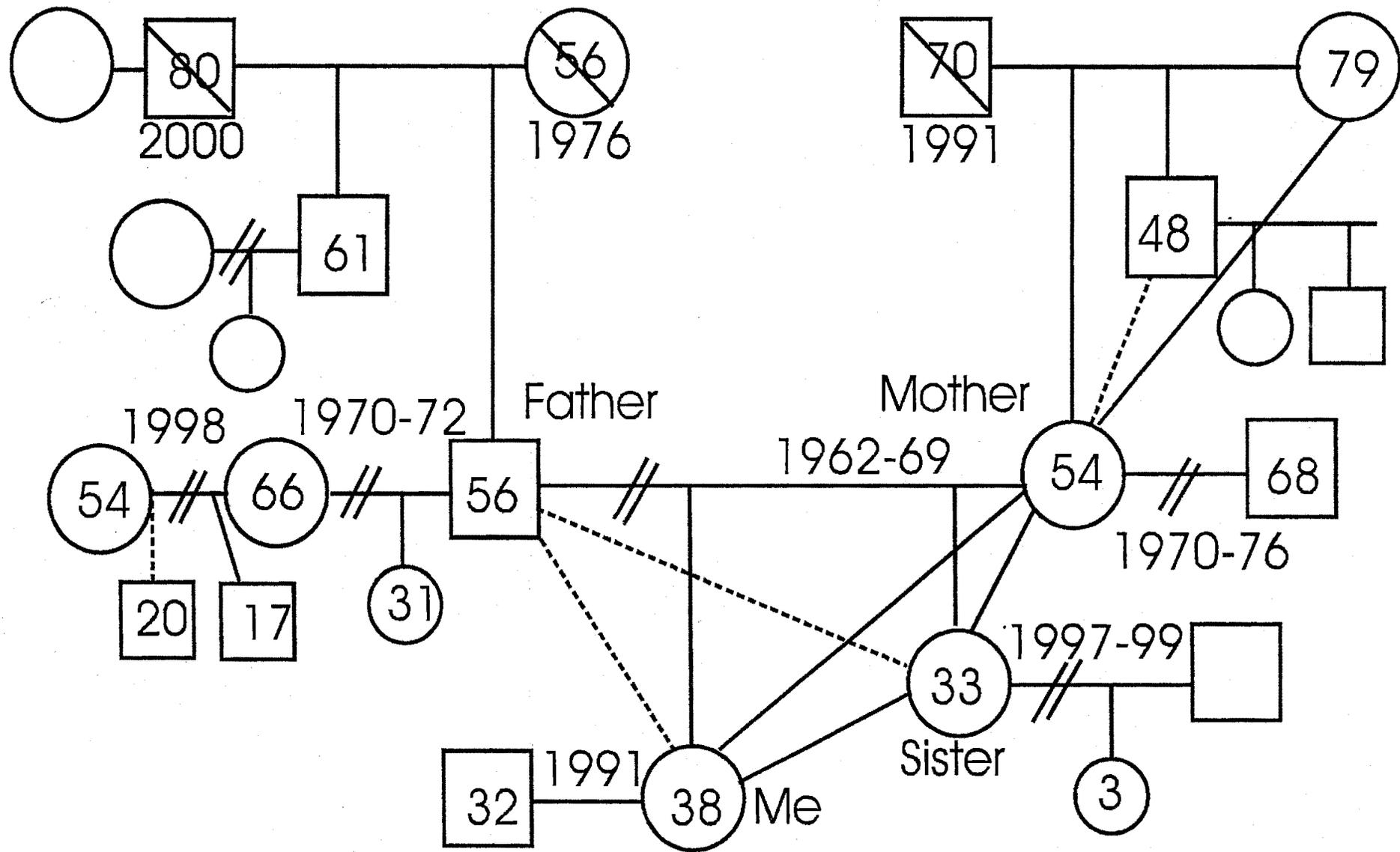


Figure 6.8 Genogram: 2000

## CHAPTER 7

### RECONNECTING THE PROFESSIONAL AND PERSONAL SELVES OF THE THERAPIST

#### Birth of the New Paradigm Researcher

“New paradigm research” is a broad label used to encompass a set of assumptions which contrast with those of the dominant positivist, empirical paradigm (Reinharz, 1981). This alternative set of principles relates to a wide variety of methods, which all fall under qualitative research methodology. According to Reinharz (1981), these methods, including collaborative inquiry, which is used in this research, have two common characteristics. They minimise manipulation of the research subjects, and they try to limit a priori analysis or definition of variables. In addition, the new paradigm researcher sets out to develop a genuine relationship with the subjects of her study by becoming a participant – which leaves open the possibility that both the researcher-therapist and her clients will change in the process (Reinharz, 1981).

Reinharz (1981) holds that the new paradigm researcher emerges through a process where, at the beginning, the researcher’s actions are based on the dominant paradigm; but through facing inadequacies and failures, rejecting the dominant paradigm, and creating alternative forms, the researcher becomes aware of the problems of the dominant paradigm and develops an innovative stance. In the new paradigm, the researcher’s awareness is the major instrument and it must therefore be finely tuned, Reinharz points out. He emphasises that researchers are not born with the ability to function within the new paradigm. They develop this approach through their struggle with failure, and in facing the limitations of the dominant paradigm.

My own research position developed in much the way described above. I started within a first-order frame, but through facing my professional and personal limitations, my position moved towards a second-order stance, giving way to narrative practice (Larner, 1995). My attention shifted from an independent, objective reality to the subjective domain of the observer (Kenny & Boxer, 1992). This self-reflective research is parallel to a hermeneutic cycle which is a process of

merging of the horizons of the researcher-therapist and the other (in my case, the thalasseemics) (Steier, 1985).

Initially, I asked the traditional research question, viz.: "To what kind of explanation of my subjects am I committed?" but as I moved towards the constructivist perspective, reflexive questions became crucial and I asked instead: "To what kind of explanation of my own research behaviour am I committed?" (Heron, 1981). During 1994 my research position fell squarely within a positivist, expert framework. My focus and explanation of outcomes at that stage were entirely outside of myself. I started out with an idea based on first-order cybernetics, believing that the patient's system is an entity that can be manipulated by strategies and interventions (Hoffman, 1988). I used an explanatory model of simple linear causality, which understands the client's interpersonal behaviour (in this case the group of thalassemia parents and children), as a simple response to whatever the therapist does, such as providing educational input to improve compliance (Fruggeri & Matteini, 1988). However, as Hoffman (1988) warns, an intentional and strategic approach to achieve change may prevent it from occurring because too much consciousness may render some desired sequence of events impossible.

At the beginning of 1995, I had made no progress with compliance, and I began to question the simplicity of the model I was using. I faced the choice of following a specific theory and fitting my clients into that theory, or taking a more open approach based on my realisation that human nature has too many facets to fit it simply into any one category (Dryden, 1985). Further on in the process, my neutral stance and objectivity were challenged through conversations that became highly emotional. I had to confront the limitations of the dominant model, which demands the researcher's neutrality and objectivity (Reinharz, 1981). My emotional participation in the process provoked a self-reflective mode. In traditional treatment approaches, most manifestations of self-reference are viewed as problematic. In the traditional framework, therapists do their best to remain neutral and prevent personal feelings from interfering with the therapy process. However, what defines the therapeutic relationship is the reality of a conscious and unconscious exchange of feelings and thoughts, and acting on those. If we accept that the therapeutic relationship has a basis in trust and connection then we need to accept that the

therapist's feelings and thoughts are the reality, and certainly not an exception (Andreozzi, 1985). The self-reflective mode I shifted into from the beginning of 1995 was the first step towards the birth, in this research, of the new paradigm researcher.

In second-order cybernetics, according to Kantor and Andreozzi (1985), clinical practice is understood as a self-referential practice and regarded as inseparably integral to the therapy process. Therefore, they argue, any attempt to understand fully the reciprocal relationship between process and outcome in therapy needs to include the therapist's personal explanatory model and construction of reality. They caution that to ignore the complexity of the therapeutic process by ignoring the therapist variables is to proceed blindly through the therapy process, at great expense to both client and therapist. The therapist's personal explanatory model includes not only the theoretical perspective she has adopted, but also her model of the ideal family, and the self-corrective mechanisms that are available to her when interacting with a particular family. The therapist's model, according to these authors, is not "a finished commodity, but rather is an evolutionary process that develops throughout a professional lifetime" (p. 40). If the research has biases, as all research does, when they are made explicit they pose fewer threats to the validity of the study's findings (Kantor & Andreozzi, 1985).

In 1995 I began to face failure. My failure promoted self-reflection, gave me feedback on the impact of my actions, which forced me to search for alternative information, encouraged flexibility, taught me humility, improved my tolerance for frustration, fostered experimentation, increased my resolution and stimulated change (Kottler & Blau, 1989).

Deconstruction of the expert stance begins with the therapist's confrontation of her subjectivity, her explanatory model and her self-search for alternatives (Reinharz, 1981) which led to an innovative stance, as described in chapter 6. As Hoffman (1985) sees it, the inclusion of the "self-of-the-therapist" is the most significant difference between first and second-order cybernetics. Second-order therapy involves the following: a collaborative rather than a hierarchical structure, goals that emphasise setting a context for change instead of specifying a change, ways to guard against too much instrumentality, a "circular" assessment of the

problem, and a non-pejorative, non-judgmental view (Hoffman, 1985). The use of self is the most important ingredient of the shift to second-order therapy. Through the use of self and self-disclosure, the therapist deconstructs her power and her hierarchical position and moves towards a collaborative stance. Her authenticity in the therapeutic encounter will open the way for more honest responses from the client, and if the therapist wants to stimulate self-analysis for the client she must be prepared to do the same (Kramer, 1985). The sessions I describe in chapter 6 support this claim: when I opened up to the “use-of-self” and self-disclosure, the group responded with a parallel. What I discovered then was that effective self-disclosure can undercut the idea of the omnipotent therapist, demonstrate empathy and build trust (Kramer, 1985).

Thus from 1995 onward, I moved away from setting goals and using interventions, and towards the second-order practice of becoming a participant in the therapy. As the sessions reported in chapter 6 show, my empathic presence created the context for a conversation that became non-hierarchical, non-instrumental and non-judgmental (Hayward, 1996). A therapist does this, according to Hayward, through exploring cultural and religious contexts and discussing the interface between the cultural and illness contexts. (The process described here by Hayward is, again, apparent in the material I provide in chapter 6.)

There is substantial agreement in the literature that the most significant change in the shift from first to second-order therapy is the inclusion of the therapist in the therapeutic context (Anderson & Goolishian, 1990; Atkinson & Heath, 1990; Becvar & Becvar, 1996; Hayward, 1996; Hoffman, 1985; Hoffman, 1988). Although all these authors agree that the inclusion and participation of the therapist make space for potential change in both the client and the therapist, there is minimal discussion, in the literature, of the real meaning of that complex process. The limitation of second-order cybernetics is that “there is no articulation of the ways in which diverse observers are coordinated in their computing of realities” (Kenny & Boxer, 1992, p. 76). De Shazer (1991) emphasises that many authors agree that the second-order position requires inclusion of the therapist, but says it is unclear what this inclusion really means in practice. What is needed instead of abstract theories is “rigorous description of what therapists do that works; what they do together that can be seen

as leading to, or prompting, or preceding the clients' description of a new and different life" (de Shazer, 1991, p. 456).

This research describes the process in all its complexity by including not only the therapeutic process and the changes that came about among the thalassemic children and parents with whom I worked, but also the process leading to the inclusion of myself, as the therapist, and the transformation that took place in my professional and personal life. I found that to take a participant role required an acknowledgment that my view was not objective or "true" but, rather, self-constructed. If second-order therapy moves away from the therapist's position as observer to a participant role then we can speculate that the psychotherapeutic relationship becomes intense and emotionally significant for both the psychotherapist and the patient. Guy (1987) points out that there seems to be an extraordinary amount of literature on the impact of the psychotherapeutic relationship on the patient compared to surprisingly little in respect of its effect on the psychotherapist's life and interpersonal functioning, and consequently very little is known about the impact of psychotherapy relationships on the personal life of the psychotherapist. If the psychotherapeutic relationship has been found to have a significant impact on the patient's life, he reasons (p. 105), then it seems reasonable to assume that it may have a noticeable effect on the therapist's relationship with family and friends. Since the use of self is probably inevitable (Collier, 1987; Satir, 1987), one can assume that the personality of the therapist will undergo some change along with the patient's change.

When, in 1995, I abandoned the expert position and moved into a collaborative stance, I was faced with my responsibility for the poor progress or impasses in the therapeutic process. Taking responsibility for incompetence and failure in my professional self meant engaging in self-analysis (as I discuss towards the end of chapter 4 and in the first part of chapter 6). Hunter (1994) acknowledges that experiencing the suffering and pain along with the family can lead a therapist to experience feelings she describes as spiritual or at least transformational and "to travel this path, exploring my own depth, being with others in their pain and anguish, is both highly satisfying and an actively risky business" (p. 85). My conversations with parents and children about their emotional wounds (refer to the conversations

about death and over-responsibility recounted in chapter 4) activated my own wounds, as Miller and Baldwin (1987) predict.

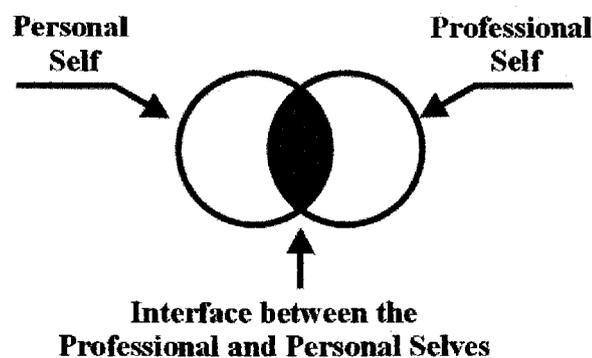
My awareness of my wounds and vulnerability forced me to look at my family of origin (see chapter 5). I faced a surfeit of unresolved emotional issues from my family of origin, and I saw that this had resulted in poor differentiation from that family and high anxiety when faced with emotional issues similar to past ones (Kramer, 1985). The physical cut-off from my family of origin that occurred when I emigrated from Yugoslavia, and the emotional cut-off arising from the emotional distance I had placed between my family of origin and me, made me vulnerable to intense relationships such as those that develop when one works with the terminally ill (Kramer, 1985).

Self-analysis, personal therapy and discussions in the supervisors' group led to a deeper awareness of the impact of my personal history on my personal relationships. I faced the need to address and manage my unresolved emotional issues and lack of differentiation (Bowen, 1978). The patterns from my family of origin were preventing intimacy in my marriage, yet I had long been unaware that my marital problems had their roots in my family of origin (Kramer, 1985). I had chosen a marital partner who was also poorly differentiated from his family of origin, so both of us brought unfinished aspects from "our" families' interfaces into our interactions with each other (Kramer, 1985). My over-responsible and over-controlling behaviour and his passive behaviour were, I saw, homeostatic (St. John, 1987) (a description of my marital relationship is given in chapter 5).

Kramer (1985) points to the danger that a therapeutic impasse may be brought about by the interlocking of dysfunctional patterns between the therapist and the client or family. Self-analysis of the impasses in which the thalasseemics and I were stranded made me aware of the interface between my professional and personal selves (Kramer, 1985). It was this which prompted my decision to work on differentiation from my family of origin, especially the cut-offs that had taken place and never been resolved.

## Interface Between Professional and Personal Selves of the Therapist

Skygger (1989) maintains that choosing psychotherapy as a career, and pursuing the professional life of a therapist, may arise from the need to make sense of the confusion with which our family upbringing may have left us. If that is, indeed, the reason for entering the profession, Skygger says it is often unconscious, and it may well be very uncomfortable for professionals to acknowledge this openly to themselves, so much so that they may end up denying it. Yet, says Skygger, the main reason for entering the profession may be the experience of denied nurturing in the family of origin (refer to the description of my family of origin, chapter 5). Guy (1987) discusses several research studies which report a frequent theme, among therapists, of feeling “different” from others, and which suggest the possibility that pursuing a career as a psychotherapist may be a means of meeting emotional needs that were unsatisfied. Williamson (1981) says: “Every time you work with a family you are trying to improve your own family of origin” (p. 9). Kramer (1985) takes the view that the therapist brings to the sessions experiences from her family of origin that have shaped her, like the manner in which she handled life cycle issues, the survival tactics she used, her view on gender, her secrets and beliefs, and the cultural patterns with which she is familiar. She also brings to the sessions her current life struggles, which may interfere with her capacity to remain available to the client (Kramer, 1985).



*Figure 7.1* Therapeutic Interface

When the therapist is able to see her contribution to a therapeutic impasse, believes Kramer (1985), she has more options for correcting the situation and can turn it into a learning experience for both herself and the client or family. She adds that the degree of safety in the therapeutic situation depends on the therapist's

willingness to experience the way her own family patterns can be triggered in the therapeutic interface.

Analysing the therapeutic interface in my own experiences, I discovered significant interference between my personal and professional selves. One of the most significant personal characteristics, which greatly influenced me in taking on the professional position of expert, was the over-responsible role I played in my family of origin. This position began with the birth of my sister, which placed me in the older, more responsible role. After my parents' divorce this position was further reinforced by the responsibilities I assumed in the household (see chapter 5).

This over-responsible position often led to over-controlling behaviour in relation to significant others in my personal life (as is evident from my description of my relationship with my sister and husband in chapter 5). The interference of this with my professional role was especially visible when confronted with passive clients, or clients with a low self-image who had difficulty in taking responsibility. In those situations I took responsibility for clients' change, subsequently feeding into their victim role with the client taking progressively less responsibility and becoming more inadequate. This process mirrored the process between my sister and me (see the analysis of my work on my family of origin in chapter 6). This pattern created a comfort position for me in the expert role and a major difficulty in abandoning this model, which was safe, for the collaborative model, which required a deconstruction of power and expertise.

My family was very secretive (see chapter 5), and I had, as a child, learnt to "walk on eggs" in the presence of secrets. Without being at all aware of it, I played the same game and "protected" the secrets from "outsiders" such as my friends and my husband, to whom I never spoke of certain issues in my family. When I saw families that had secrets, there was a side of me that immediately resonated to the "secretive family side" and I was so scared of the secret coming out into the open that I was often not as useful as I wished. My fear blocked my creativity, and I would find myself doing the same as I had always done – "walking on eggs". The interesting fact is that, when I began to address my difficulty with secrecy in personal therapy in 1995, it seemed that on some unconscious level I started sending a different message to my clients, because from around the beginning of 1996, in

sessions with the thalasseemics, many secrets came out (see chapter 6), and a parallel process occurred in my therapies in private practice. I am not sure how this process works, but my conjecture is that when I was able to face the abuse and other secrets in my personal history, my clients somehow felt safer and were able to disclose their own secrets to me.

My fear of my own vulnerability, and seeing it as a weakness, made me hard not only on my family and myself, but also on my clients. My inability to relate to feelings of vulnerability allowed my clients little room to grow comfortable with their own feelings of vulnerability. I now see this as a fear of confronting my victim position when I was very small. The abuse from my father was so traumatic that I have no memories of my childhood before the age of about 10. When clients brought similar traumatic events to their therapy sessions, I was unable to connect with their vulnerable side for fear of getting in touch with my own vulnerable and helpless self. As a result, I had very few clients whom I can remember crying, sobbing, or breaking down in front of me in any emotional way. I can see now how I dealt with the first signs of tears by moving the focus, asking all sorts of questions and ultimately dealing with the client's feelings in an intellectual rather than in a real, emotional context. I was scared to be confronted with someone's feelings, and in one way or another I blocked their process and channelled it to the intellectual side, with which I was so much more comfortable. My strong cognitive orientation and my weakness in dealing with emotions explains why I chose an approach that emphasised the therapist's expert position, knowledge, and interventions rather than the self. Difficulties in dealing with my vulnerability affected my ability to remain emotionally available when thalasseemics spoke of emotional issues such as death (refer to the conversations reported in chapter 4).

My control issue and my need to be in the expert role relate to my position in my family of origin and the over-adequate role I played in it. It makes sense that my professional development and preferred theoretical model began with a cognitive model and a very instrumental approach to therapy, like the behavioural approach (refer to my professional history, which is sketched in chapter 5). Even when I discovered family therapy (see chapter 5), I preferred an "expert approach", which gave me a sense of power and control. This position, however, blocked my ability to

deal with clients who challenged my expert role, and made others dependent, passive recipients of the therapeutic process. This issue was apparent in my instrumental approach to and simplistic understanding of compliance (see chapter 4, in which I describe the educational strategy I adopted in this regard).

My cut-off from my family and poor level of differentiation were projected into an over-involvement with my work, where I sublimated my need to reconnect with my family in the feeling of being needed by patients. I tended to minimise the importance of this cut-off and was perhaps unable to create a supportive space for some clients who needed to address similar issues (see, for example, the conversation, recounted in chapter 6, with N.C. about her father, in which I make no attempt to question how she was affected by the cut-off she mentions).

My non-existent relationship with my father, my lack of understanding or even of attempting to understand him, blocked my ability to relate empathically to male clients, especially when they showed any vulnerability. This is evident in my reactions to the stories told by V.H., M.P. and Z.S. during our sessions in 1995 (see chapter 4).

My experience of religion in my country, and the civil war during which many atrocities were committed for religious reasons, created intense discomfort for me in talking about anything to do with religion. In consequence, I over-generalised the role of religion in human life. For me, religion was an evil force – something that could destroy people and their lives. My prejudices about religion thus interfered with my ability to see its positive impact in the lives of the thalasseemics during 1995, and even in 1997 I was, at times, unable to facilitate any conversation on this subject.

It was problematic for me to deal with disagreements, differences in position and anger, stemming from my experience in my family of origin, where any disagreement or difference ended in a cut-off. This made it difficult to take risks with clients and to express anything that could lead to open anger. My discomfort in the presence of anger probably meant that clients who were angry did not feel understood. Such lack of empathy from the therapist is likely to lead to negative responses like defensiveness or early termination of therapy. These are exactly what I discovered when I searched back for clients with whom I had felt stuck or clients whom I did not like or who had left therapy after just a few sessions.

## Complexity and Change

Hoffman (1988) explains that second-order therapy is not indifferent to change but refrains from prescribing and imposing the view of the therapist. Outcome is not attributable to the therapist's intervention but to structural coupling (Chapman, 1993), which, say Becvar and Becvar (1996), refers to the degree to which the client's system and that of the therapist mutually coexist. Structural coupling is liable to change both the therapist's structure and the structure of what he or she is observing (Hayward, 1996). Moreover, in terms of the second-order approach, one system cannot determine or instruct the conduct of another because all changes that the system undergoes are necessarily determined by its own organisation (Kenny & Gardner, 1988).

In group therapy, according to Kramer (1985), interpersonal learning is a primary factor allowing members to gain awareness. She holds that, in sharing similarities and differences, group members become aware of their own and alternative perspectives, which creates space for change. This mutual exchange forges a bond between members and helps them see their own lives from a different perspective. Kramer suggests several areas of exploration.

The first relates to the client's readiness to identify the problem but lack of readiness to change. This may be seen in some of the conversations with V. H. (see the conversations reported in chapter 6 about the desferil pump and compliance) and Z.S. (conversations about the pump, chapter 4).

A context for change, says Kramer (1985), can develop through sharing thoughts and feelings in the group. In the thalassaemic groups, there was a major shift from minimal sharing during 1994 and at the beginning of 1995, to deep, meaningful sharing from the middle of 1995 onwards (see chapter 6). This process of sharing feelings and thoughts between the parents, children and myself promoted greater awareness of the side effects of the lack of communication and secrecy (refer to the conversation with V.G. and S.A. on the issue of HIV and secrecy, reported in chapter 6). The process also encouraged greater honesty and better communication between parents and children (see S.G.'s description of change in relation to her mother and herself, chapter 6).

Setting limits can be extremely difficult for someone who struggles with assertiveness (see S.A.'s description of herself in chapter 4) but one of the contexts for change mentioned by Kramer (1985) relates to establishing clearer limits (see S.A.'s account of setting the limits, chapter 6).

Acceptance of oneself and correcting distortions (Kramer, 1985) can be increased through discussions about present and alternative options. This process can be facilitated greatly in group discussions where group members share their differences. Such a process can be discerned in several of the discussions in the parents' group (e.g. the discussion about addiction and abuse, chapter 6; the conversation about gender and culture, chapter 6; and the conversation about coping mechanisms, also in chapter 6). The contributors to these conversations raise their idiosyncratic voices in an attempt to make explicit the ways in which we participate in the therapeutic conversations (Kenny & Gardner, 1988).

Interpersonal interactions are also very useful in building and facilitating awareness of different thoughts and feelings (Kramer, 1985). Many of the conversations with mothers, reported in chapters 4 and 6, describe this process clearly.

Therapy is an activity which "expands and elaborates upon the unsaid" (Goolishian & Winderman, 1988, p. 141). When I asked for feedback on the therapy process and on my way of participating, group members agreed that the process changed. When asked to describe that change, one of the mothers (V.L.) said: "It was your approach that changed. When you came in it was more your theories. It was all about sickness. We also related to you in a different way. Later we started to talk about real things. We got to know each other and you." Another mother (N.C.) said: "In the beginning it was all about what we should. We had enough of that. Everybody was telling us what we should but nobody cared how difficult it was to get where we should. You were the first person we spoke to about that." Another comment (from D.T.) relates to the expansion on the unsaid: "We got to speak about other important things." Furthermore, the conversations with V.H. during 1996 and 1997 focused particularly on bringing his unspoken fears and thoughts out into the open (refer to chapter 6).

The art of reframing relates to a change in the conceptual and/or emotional setting or the viewpoint from which a situation is experienced, and placement in another frame which changes its entire meaning (Watzlawick, Weakland & Fish, 1974). One of the most amazing instances of reframing that I have observed took place in 1997, in relation to the way in which parents and children responded to V.H.'s death. In the past, such occasions had been framed as a prediction that "I am (or my child is) going to be the next to die", which had invariably resulted in a major deterioration in compliance regarding use of the pump, and an attitude of: "Who cares, I am going to die anyway." But in 1997 the group responded to V.H.'s death in a very different manner. Everyone reported greater efforts to improve compliance, resulting in continuing improvements in ferritin levels, compared to the past when compliance had plunged drastically each time one of the thalasseemics died. I am not entirely sure how they did it, but what I witnessed was evidence that, somehow, the parents and children placed V.H.'s death in a frame that allowed them to create positive motivation and therefore act in an entirely different way.

The constructivist approach sees reality as invented by an observer and as a subjective experience, therefore time itself is also regarded as a shared construction of humans (Boscolo & Bertrando, 1993). The personal meaning we give to our experience changes over time. "Our humanness is expressed through our capacity to narrate", say Boscolo and Bertrando (p. 140). Discussing the narrative approach in relation to time, they point out that when we have only one story to tell, our future options are drastically reduced. In narrative theory, the family is seen as a set of interwoven stories drawing on events from the past. Boscolo and Bertrando say that these stories not only shape the past and present but may also impose severe constraints on how family members construct their view of the future. Just as stories may change over time, so may their meaning; and when our sense of time is constrained, this may result in a loss of meaning.

In my work with the thalassemic families, stories of hopelessness and inability to see the future were brought into the open in several discussions (see the conversation with Z.S. reported in chapter 4; and with V.H. in chapter 6). In therapy, the story clients bring is jointly deconstructed and reconstructed by the client and the therapist. Such a process can promote a change in the meaning of the story. This new

meaning relates to the building of hope, which strengthens the ability to dream and to plan the future (refer to the discussion with R.C. and N.C. about their plans for the future, recorded in chapter 6). The ability of the thalassemic children and their parents to accept illness and at the same time place it in a larger life context was reflected in a change in their perception of illness as the only aspect of life to seeing it as just one aspect of their lives. This process reflects a greater level of adjustment (Wright & Kirby, 1999). The change was, perhaps, triggered by our conversations, but there are many other factors that could also have provided the necessary impetus. Some of these will remain unknown, but one can speculate that some may have been the increased maturity that comes with age, or new and exciting responsibilities and relationships which increased the level of autonomy and provided more space to develop other stories.

The work with the thalasseemics had a profound influence on my professional and personal selves. When the prescribed change in compliance did not occur and I confronted the poor progress that had been made, I began to search for alternatives. In the process that followed, some of the discussions challenged my emotional equilibrium (see my conversations at the beginning of 1995 with Z.S. & M.P., and with V.H., recounted in chapter 4). Participating in a patient's "emergence" can be a profoundly moving experience, and one which stimulates growth in the therapist (refer to the sessions with V.H. in his last days of life, described in chapter 6). If we approach the therapeutic situation as a dialogue in which both sides are creating space for learning in a mutual exchange, then we also acknowledge the mutual influence between client and therapist, in contrast with viewing the therapist as the expert. Whitaker (1989) understands therapy as a growth process in which both therapist and client share and from which both benefit. Spinelli (1994) describes the therapeutic encounter as a process that is not solely directed towards the client. He argues, "if the therapist is truly engaged in this encounter, then a similar challenge and possibility emerges for the therapist" (p. 340). My increased awareness, in my encounter with the thalasseemics, of my personal wounds prompted my decision to address these hurts through personal therapy, discussions in the group of supervisors, and work on my family of origin. This, in turn, provoked numerous transformations in myself, my marriage and my family of origin, which triggered parallel changes in

my professional self (Kramer, 1985). The work on self and family of origin ultimately enhanced my professional competence.

In second-order therapy the therapist's position is collaborative, one of mutuality and respect (Anderson & Goolishian, 1988). We take a position of curiosity, which requires that we are ready to risk entertaining alternative options and meanings (Anderson & Goolishian, 1988). We must therefore be prepared to let go of old meanings, just as we expect our clients to do. In this process, we ourselves may experience personal and professional change.

Watzlawick et al. (1974) say that it is through tunnel vision that we simplify the complexities of interaction in social systems, and that we maintain this view through defining our tunnel vision as a realistic and objective stance. A similar process occurs when the therapist believes that the client's change is a direct result of her interventions in therapy. Such a belief leads to a simplification of the complexity of human change. Interpersonal behaviour cannot be considered a simple response to whatever others do, but should rather be seen as a function of the meaning attributed to such actions (Fruggeri & Matteini, 1988). Complex causality is that which describes output as the result of a process which, though triggered by the input, is characterised and developed according to its own autonomy (Fruggeri & Matteini, 1988). Thus in first-order therapy, the therapist changes the system, whereas in second-order therapy change is attributed to the co-evolutionary process of the system constructed through the therapeutic narratives. In the second perspective causality is based on a model of complexity whereby the change is a function of the system structure (Fruggeri & Matteini, 1988). Hoffman (1988) emphasises that second-order cybernetics implies that one can perturb the client or the family, but one cannot predict the outcome. We may speculate that in a process where the therapist is a participant, a similar process may occur for the therapist. The therapist could therefore be perturbed by the client, but here, too, the outcome might not be predictable. As for change – it takes much more than just perturbing one side or the other. Timing is one of the major components. How many of us wonder why the same approach triggers such different outcomes with different clients? One of the very significant contexts for change is the time context, which has a direct bearing on a person's developmental stage. Time provides a structure from which one lives,

develops and changes. At a certain time of life, one may be more or less ready to embrace change, and timing is in direct relation to personal and/or professional experiences that may or may not promote the change. In general, time also brings a difference in respect of the personal/professional focus. A young person is inclined to focus on expanding his or her knowledge and education, while ageing brings maturation with a heightened emphasis on feelings and emotional states (Carsten, Isaacowitz & Charles, 1999).

Thalassemia parents and children had, over the years, seen their helpers come and go and had experienced very few doctors as having a long-term commitment to them. When I entered the picture, my time frame was also short-term. In one of our discussions I became aware of this difference in timing (refer to the conversation with the children about outsiders, recounted in chapter 4). What I learnt from those conversations was that the first step in building trust and setting a context for change would be my making a long-term commitment to working with them. That commitment was reinforced by my decision to submit a proposal for a doctorate, which increased my motivation for long-term involvement with the thalasseemics, although at the time I was unaware of this connection.

When I began working with the thalasseemics, it was 2 years after immigrating to South Africa, at a time when we were beginning to settle into the routine of life in this country. The outside elements, such as jobs, a flat and transport had been settled, and suddenly there was more space for internal issues. So when some of the more emotional conversations with the thalasseemics took place, I was more ready to look at myself. In respect of my family of origin, I think my physical distance created a safety net and at the same time an emotional distance that allowed me to “go back” when family issues were triggered by conversations with the thalasseemics.

Another important context for change, apart from time, is the context of interpersonal relationships with significant others. When I decided to reconnect with my sister in 1996 after 10 years of cut-off, her agreement to meet me did not come out of my readiness, but out of her life position. She was feeling safer than at any previous time because of her position as a wife and mother (see chapter 6). Her position of helplessness and inadequacy had shifted with her occupation of new roles that proved her adequacy.

When I faced my issues with my mother and attempted to address them in 1996, I made limited progress, but achieved major progress in 1998. From this perspective I see our interaction being affected by the space she occupied in her personal and family relationships at those different times, but of which I was unaware at the time. In 1996 her relationship with my sister after 2 years of cut-off was beginning to heal. But the most healing process, I believe, was the development of her relationship with her granddaughter, my sister's child. My observations and some of my mother's comments in the past few years have made me think that, through that relationship, she has been able to love and be loved in ways she missed in her mothering because when she had me she was just 16, so young and unprepared for motherhood (refer to chapter 5). Her relationship with her granddaughter created a context for growth and improved self-esteem, which led to a greater ability to face the negative sides of her that were brought out in my conversations with her. This is just one of the possible factors which affected the process of change between my mother and myself.

With regard to my father and me, change was limited in terms of where we got to in relation to each other, but for me, just being able to face him on equal terms was a monumental change. My knowledge of his past and present life was and remains minimal, which curtails my ability to know and understand how, if at all, our meeting and few conversations affected him.

I have no doubt that the picture in respect of contexts for change is even more complex than the one I have sketched here, but the point is that the context for change requires synchronicity between many aspects of human life as well as between many human relationships. Hence, when we therapists claim that our interventions or strategies have resulted in a client's change, we are looking at the process with the tunnel vision that Watzlawick et al. (1974) say allows us to hang on to our over-simplifications. Watzlawick et al. describe second-order change as an unpredictable process that comes "at the end of long, often frustrating mental and emotional labor" (p. 23). Second-order change, or what these authors term "change of change", brings internal transformation and therefore creates a fundamental change in one's meaning (p. 11). This change is, they say, unpredictable, uncontrollable and outside of logical process. When the change is a change in the

person's internal structure, then one is able to transfer the learning from one context to another. Thus when one works towards differentiation in relation to one's family of origin, the change in the personal self will be transferred to the professional self and professional competency will increase (Kramer, 1985). Describing how work on the family of origin improves therapists' clinical work, Bowen (1978, p. 531) says "it became clear that it was precisely those residents who had done best in the effort with their parental families who were also doing best in their clinical work."

It can become increasingly difficult for the therapist to avoid and deny problems with her own family when constantly faced with the ongoing emotional material discussed with clients (Guy, 1987). Facing my vulnerability, connecting with my helpless position in childhood and subsequently meeting my father in 1996 (see chapter 6) dissolved the anxiety I had experienced around uncertain, unpredictable situations, which was related to terrifying childhood experiences where my father had total control over me. Learning some pieces of his story made me aware of the complexity of the cycle of abuse, anger and anxiety. I no longer fear my father; I find in my heart a curiosity about the person my father is, and whom I may never get to know. I feel sadness for his pain and the many failures in his relationships. Interestingly enough, in my private practice the number of male clients, clients with generalised anxiety and clients who have difficulty with letting go of their anger, has steadily increased. This may be no more than a strange coincidence, but I see it as a development that is indirectly related to the developments in my relationship with my father.

Facing and dealing with my vulnerability in my personal life sharpened my awareness of how clients' stories can trigger my vulnerability, and increased my capacity to constructively deal with that (Weisman, 1993). Sharing this process with my husband, my mother, personal therapist and friends was endless practice in creating a context for change. This increased capacity to share my vulnerability became visible in my professional self. Dealing with the emotional parts of myself unblocked my empathy for clients who struggle with the same problem. I am now able to sit with pain or tears without jumping to interpretations. I can be silent and let silence linger for the time that is useful to clients. I have been able to cry with my clients, and when the process gets stuck I am able to detect which parts of me are

maintaining the difficulty without getting defensive, and I can share some of this with the client (refer to chapter 6, last moments with V.H.). Kramer (1985) believes that when the therapist takes the risk and expresses emotions or thoughts she feels with the client, she is also modelling for the client the freedom to express his or her own thoughts and feelings. When the therapist speaks of her feelings of helplessness or insecurity, more honest dialogue can open and that honesty, says Kramer, gives permission to both the therapist and the client to identify and discuss further impasses when they happen.

Addressing my over-responsible role with my sister, my mother and my husband helped me in my more honest positioning with clients. As Kramer (1985) points out, the therapist who is over-responsible and burned out herself is not an effective model for her clients.

The symptoms of unresolved emotional issues stemming from the family of origin often appear as marital conflict or dysfunction in a spouse (Bowen, 1978). It is possible that if a person is cut off from his or her own family, the need for connection may be achieved by fusion with the spouse. Framo (1976) contends that marital difficulties are essentially an elaboration of problems the spouses had in their original families. My work on my family of origin therefore advanced my personal growth and increased my tolerance for my real self (St. John, 1987). This improved my ability to tolerate differences in opinion, which in turn provided more space for open disagreements between my husband and me. This demonstrates the aptness of Guy's (1987) observation that the personal growth a therapist experiences may serve as a catalyst for growth in the life of the therapist's spouse.

As my self-esteem improved, I was able to let go of my over-controlling, over-responsible role, and with this came some major transformations in our marital system. I learnt to trust my husband and to interact with him on a more equal footing. I have been able to receive caring from him, and to share my vulnerable moments with him, leading to greater intimacy. In the past few years I have also shared with him many personal and family secrets that I had kept hidden in the pasts.

Accepting my real self as being free to be my self and acknowledging my self as an individual with both negative and positive characteristics (St. John, 1987) (see the analysis of my over-responsible position with my sister, my mother and in my

marriage, in chapter 5) led to improved tolerance of clients' critical comments and increased resources for constructive dialogue (St. John, 1987).

My work on cut-off relationships and my family of origin has created a healing space and has minimised my need to over-connect with my work. I believe that it has also been partly responsible for my resignation from Coronation Hospital, where I gave my best but was unable to let go and invested far more of myself than was reasonable. In my private practice I am now seeing several families with adult children who have similar histories of secrets, abuse and cut-offs. I have been effective in these therapeutic interactions, and am making good progress. In such work, taking risks and creating corrective emotional experiences for the family members may be of a great significance. In addressing my own personal difficulties and dealing with my family of origin I took many risks, which brought about substantial shifts and progress (see the description of my work on my family of origin in chapter 6). That process increased my ability to take more risks with clients and to push them when necessary. Taking risks by breaking through the fear and having the courage to address my family secrets has increased my capacity to deal with clients' secrets by engaging in the process and acknowledging their anxiety, and this has created a context for several of my private clients in which they could disclose secrets kept hidden for years and from everybody.

The work with the thalasseemics brought an awareness of the positive impact religion had and continues to have in their lives (see chapter 6). Speaking of therapists' biases, Spinelli (1994, p. 358) acknowledges:

In their attempts to be flexible, therapists must be prepared to challenge not only their personal biases, assumptions and viewpoints which place their sedimented self-construct in competition with that of their clients in a general sense, but also those aspects of their sedimented self-construct in the particular sense of self-as-therapist which provide them with the power and biases to compete with, and, more often than not, succeed in reshaping their clients' self-constructs so that they reflect their (i.e. therapists') own.

I have learnt to incorporate patients' religious and spiritual beliefs into my therapeutic practice and I believe that my willingness to confront my religious and

spiritual stereotypes encourages the conversations necessary for healing (Ross, 1994).

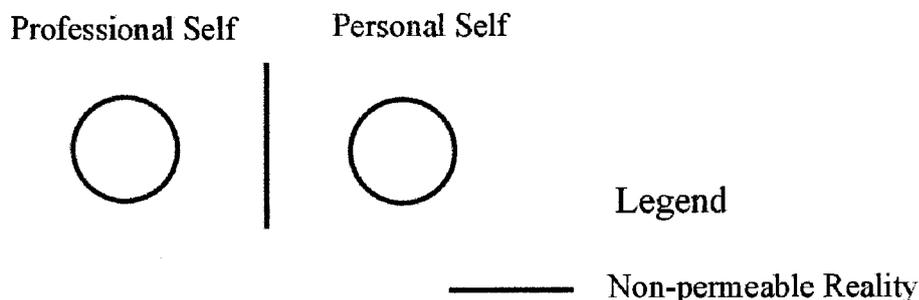
Looking back, I see a huge amount of hard work, and many emotional blockages that have been confronted, but I see, also, many more imperfections to work on. Charny (1982, p. 51) warns therapists “to be aware of ambivalence and incompleteness in family life” and urges them to develop the capacity to tolerate and live with imperfection. This process of improving the therapist’s personal and professional life is, I believe, a life-long journey in which looking at the process rather than at the end product moves us closer to understanding the second-order stance.

## CHAPTER 8

### BEYOND CYBERNETICS

#### Theoretical Implications

In first-order cybernetics the professional and personal selves of the therapist are disconnected. This means that the professional self is blind to the interface between the professional and personal selves, which opens up the possibility of potentially harmful interactions between these two parts of the therapist.



*Figure 8.1* First-order Position: Professional and Personal Self of the Therapist

Examination of the first-order stance suggests that the first-order therapist sees herself, the therapeutic process and her clients in a specific way. The first-order therapist believes the following:

1. Her professional self is an objective observer, free from biases.
2. She is an outside observer of the client's system.
3. She has the necessary expertise and knowledge to help the client.
4. She has the power to resolve the client's problem.
5. Her personal self is subjective and damaging.
6. The influence of her personal self should be controlled.
7. She can produce change by using interventions.
8. The one who should change is the client.
9. Change in the client is a result of her intervention.

In Figure 8.2 the first-order position of the therapist's professional self shows the cut-off relationship between the professional and personal selves, family of origin, nuclear family and life experiences. Bowen (1978) points to the potentially negative influence of a cut-off in one relationship on other relationships. Therefore, we can speculate that although the professional self believes that cutting off provides

neutrality in the therapeutic reality, it is more likely that it has a negative influence of which the professional self is unaware. On the other hand, the professional self is deeply influenced by professional training and knowledge, and the professional community's view on how successful (or otherwise) the professional self is. The relationship with the client is characterised by a one-way influence whereby the professional self uses interventions to influence the client.

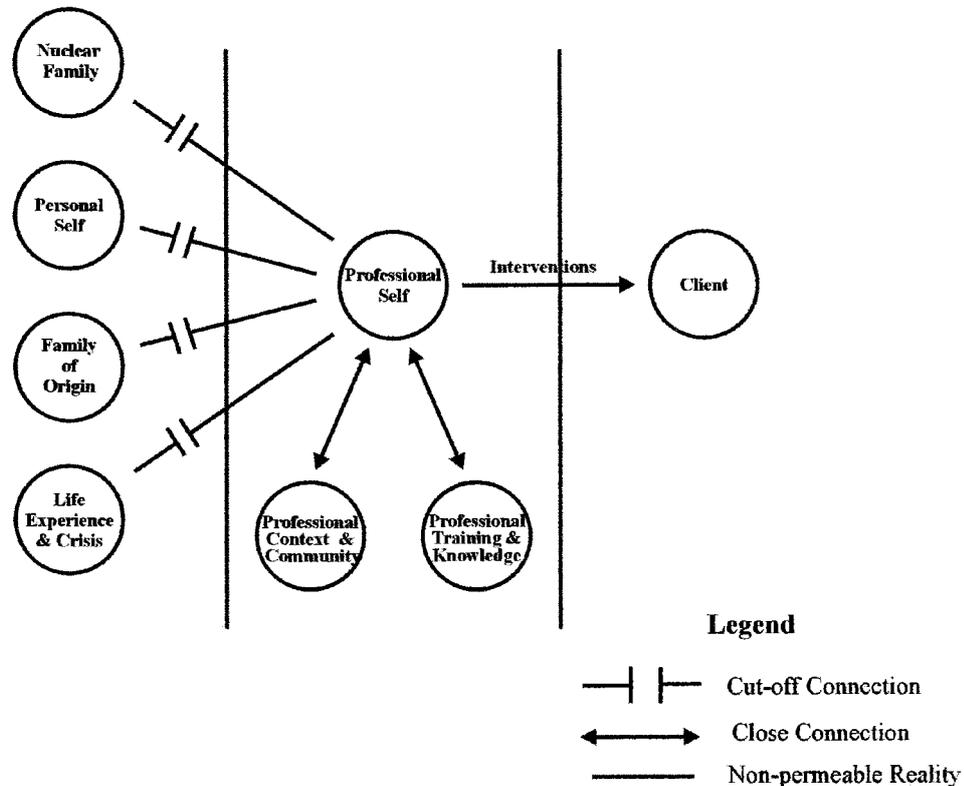


Figure 8.2 First-order Cybernetics: Influences on the Professional Self

The shift from a first to a second-order position in relation to the professional and personal selves follows the route from a disconnected, cut-off relationship between the two selves in the first-order position, to developing a connection in the first-and-a-half-order position and reaching integration of the professional and personal selves in the second-order position.

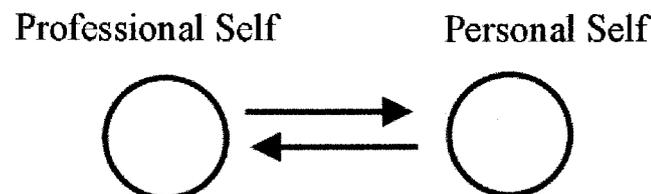


Figure 8.3 First-and-a-half-order Position: Professional and Personal Selves of the Therapist

When the therapist is struggling, the dominant model might fail to provide the answers he or she needs. This situation may encourage the therapist to adopt a first-and-a-half-order position, where the reality of the professional self becomes permeable, thereby allowing numerous influences between the professional self and the client, as well as in relation to the personal self, family of origin, nuclear family or life experiences (see Figure 8.4). However, as those influences become more significant or meaningful, professional training and knowledge and the importance of the professional community begin to take second place. Subsequent self-analysis and self-searching in relation to the personal self or life experience allow the professional self to take an innovative stance.

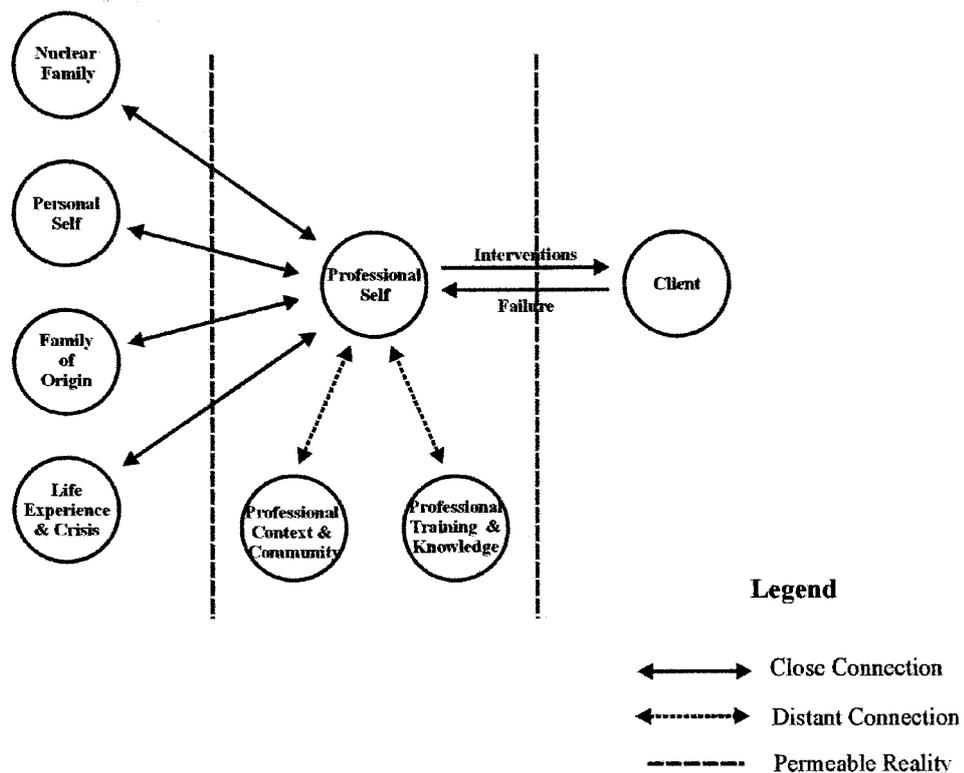
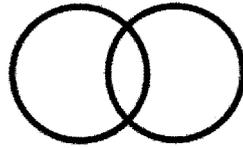


Figure 8.4 First-and-a-half-order Cybernetics: Influences on the Professional Self

Finally, when the therapist's professional and personal selves unite, the professional and personal selves of the therapist are then both permitted to participate in the therapeutic encounter. This is a second-order stance.

## Professional Self    Personal Self



*Figure 8.5* Second-order Position: Professional and Personal Selves of the Therapist

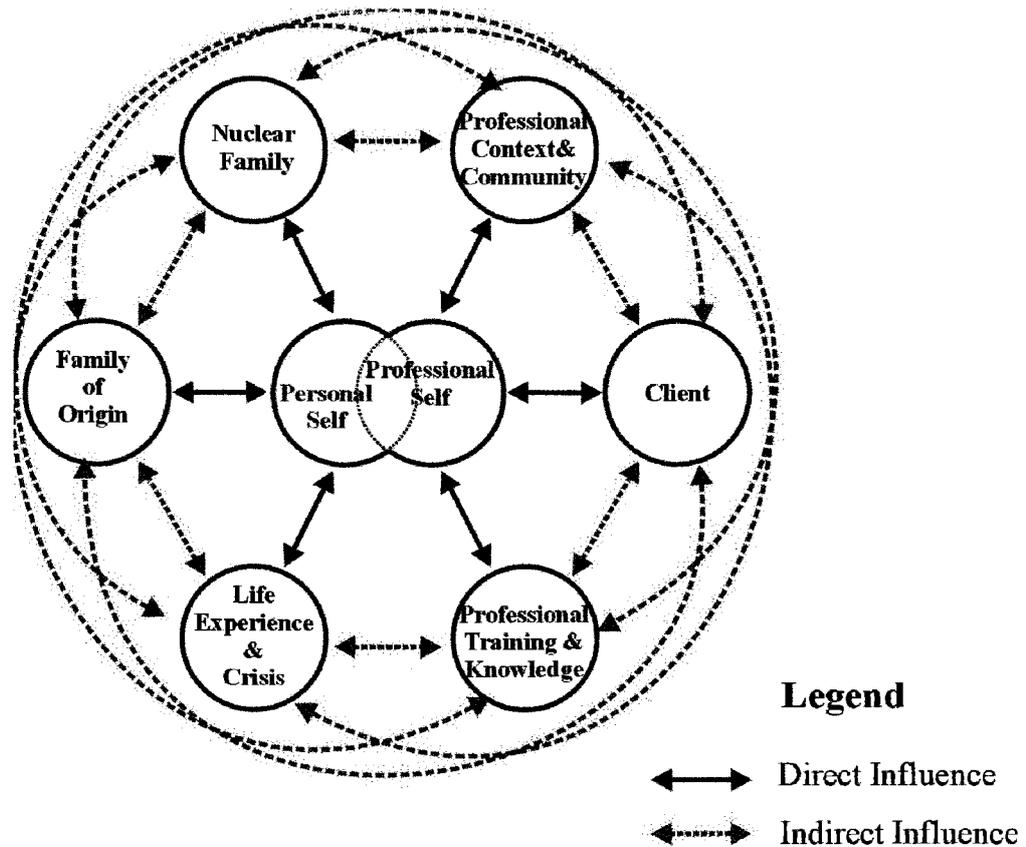
Second-order therapy involves the following characteristics: a collaborative rather than a hierarchical structure, goals that emphasise setting a context for change rather than specifying a change, ways to guard against too much instrumentality, a “circular” assessment of the problem and a non-pejorative, non-judgmental view (Hoffman, 1985). The first-order therapist uses only his professional self, which is apparently objective and has expertise. In the second order the inclusion of the therapist through the use of self is the most important component of the position.

The second-order therapist sees the personal self in a constructive manner, recognising that through the use of self and self-disclosure he deconstructs power and the hierarchical position and moves towards a collaborative stance. A second-order position is reflected in a specific view that a second-order therapist would hold, encompassing the following assumptions:

1. Her professional self is subjective.
2. She is part of the system.
3. Knowledge is not enough to be useful to the client.
4. Both parties have power in the process.
5. She cannot *not* use her personal self in the process.
6. She can use her personal self constructively.
7. Her role is to promote a context for change.
8. Change is triggered by therapeutic conversations, but is the product of multiple influences.
9. Change may occur in both the client and herself.

In the second-order position there is an interconnectedness of influences. In Figure 8.6 below, the unbroken lines represent direct influences while the dotted lines represent indirect influences. The diagram is based, broadly, on quantum

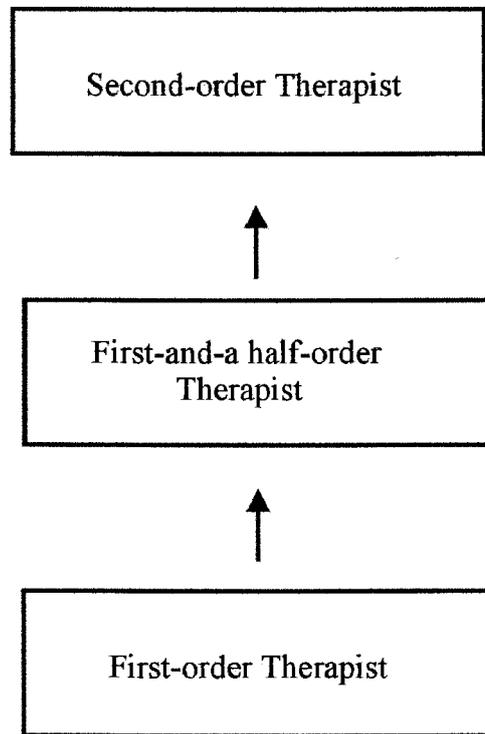
theory, which suggests universal connections between different aspects of reality (Doherty, 1986).



*Figure 8.6* Second-order Cybernetics: Interconnectedness of Personal and Professional Influences

There is a significant amount of literature devoted to the description of the first and second-order positions, but what remains unclear is how the therapist shifts from one stance to the other. Kenny and Boxer (1992, p. 76) point out that a major flaw of the second order is that “there is no articulation of the ways in which diverse observers are coordinated in their computing of realities.” De Shazer (1991) emphasises that many authors agree that while the second-order position requires inclusion of the therapist, it is unclear what this inclusion really means in practice.

To answer this question we need to understand that a second-order stance does not just happen and that therapists are not born as first or second-order therapists; they develop characteristics which reflect more of the one position than of the other.



*Figure 8.7* Developmental Process: First-order Position to Transitional First-and-a-half-order Stage towards Second-order Therapy

Let us look at the parallel between the position of the dominant or first-order researcher and the new paradigm or second-order researcher. Reinharz (1981), speaking of the researcher's position in relation to the old and new paradigms, describes the move from the one to the other as a development in which the researcher starts by acting from the dominant paradigm. Upon facing inadequacies and failures, he becomes aware of the problems of the dominant paradigm and rejects it. Forced to create alternative forms the researcher ultimately adopts an innovative stance (Reinharz, 1981). In the new paradigm, the researcher's awareness is the major instrument and must thus be finely tuned (Reinharz, 1981). However, just as first and second-order therapists are not born but moulded by circumstances, new paradigm researchers shift into that position through their struggle with failure and by facing the limitations of the dominant paradigm (Reinharz, 1981).

We can therefore speculate that a therapist's change from the old paradigm and a first-order stance to the constructionist paradigm and a second-order position is a developmental process (figure 8.7). In such a process the change would start when the therapist faces the limitations of the old paradigm. This research describes such a process where, as therapist, I faced the limitations of the dominant model, which

made no provision for the use of my self. As Reinharz (1981) points out, facing the failures and inadequacies that result from the dominant paradigm leads to self-searching and innovation. However, reaching this innovative, second-order stance requires development of the therapist's professional and personal selves to the specific level that will allow therapeutic functioning according to a second-order stance. However, I would argue that to get to this position the therapist will need to develop and change through a slower, more complex process than is suggested by Reinharz (1981).

My discussion so far, and the figures provided, point to a significant qualitative difference between the position of the first-order and second-order therapist. The question that needs to be answered is: What are the professional and personal prerequisites that will facilitate the move towards a second-order position? This research suggests that the first step towards a second-order position is the development of the therapist's ability to face her own failure without blaming the client or becoming defensive. However, professional training and the professional community promote the idea of therapeutic competence without at the same time proposing constructive ways of dealing with failure. Conversations about professional failure tend to be marginalised, which leaves minimal space for open discussion of the subject (Wendt, 1997). As Kottler and Blau (1989) observe, the abundance of success stories in the literature compared to the few accounts of therapeutic failure may well encourage a lack of tolerance of failure (Kottler & Blau, 1989).

It seems, therefore, that we need to promote greater honesty within our professional community as well as in our own process (Wendt, 1997). A therapist's training should incorporate a greater tolerance for failure and allow constructive discussions on the issue of therapeutic failure. A supervisor's ability to share fears of incompetence and failure would promote second-order training, and the co-constructing of a context of personal and professional honesty might trigger change for both supervisor and trainee.

The next step towards second-order process is self-referential practice, which should be regarded as inseparably integral to the therapy process (Kantor & Andreozzi, 1985). Self-analysis leads to a greater degree of emotional freedom for

the therapist (Bernardi & de Leon de Bernardi, 1993). Questioning of the self-position and the readiness to see that the client's view is as true as her own leads the therapist to an awareness that her own views are as subjective as those of the client. The first-order position is reflected in the belief that the therapist's view is objective and somehow more correct than the client's. The most significant difference between the first and second-order stances is the observer's awareness of her own position in the observing system. In a first-order approach, the observer is unaware of her own role in the observing, while a second-order perspective allows her to start seeing the connections between the observer and observed as mutually influenced. Any attempt to understand fully the reciprocal nature of the therapeutic relationship, process and outcome needs to include the therapist's personal explanatory model and construction of reality (Kantor & Andreozzi, 1985). Accordingly, a second-order approach requires that the therapist develop an ability to deal with the complexity of the therapeutic process. This complexity is reduced and ignored in a first-order approach, where the therapist has no awareness of herself as a significant variable and proceeds blindly through the therapy process at great expense to both client and herself (Kantor & Andreozzi, 1985).

The ability to take a position where one's own stance is just one of a number of possible positions requires the therapist to tolerate the uncertainty of her own position as not necessarily being the only correct or true one. The inclusion of the therapist, which in fact means the inclusion of the therapist's personal self, is a further important factor. For that the therapist needs to reach a level of maturity and confidence that allows her to develop curiosity, a position that involves the risk of entertaining alternative options and meanings (Anderson & Goolishian, 1988). A position of curiosity means that the therapist must be prepared to let go of old meanings just as she expects the client to do.

Developing a second-order stance means changing the way we see the power differential in the therapeutic relationship, since mutual influence and the therapist's active participation are intrinsic to this stance (Becvar & Becvar, 1996). From a second-order perspective, we can say that it is impossible not to be influenced in participatory therapy, therefore if the client is perturbed, so, too, is the therapist. The participatory position and collaborative approach do not exclude the presence of

power, but they do engender a different view on power, where “we have to begin thinking of ourselves more humbly as participants who have been invited to co-drift with members of the families rather than ‘change agents’” (Efran & Lukens, 1985, p. 74). Power can be said to be present in a process in which one person produces a consciously or unconsciously intended effect on the behaviour or feelings of another person (deVaris, 1994). Power is not in itself positive or negative, but needs to be judged in its effects on others (Chapman, 1993). Therefore deconstruction of power does not necessarily mean that the therapist needs to pretend to have no power, but if therapy is defined as a process in which both the therapist and the client influence each other and change each other, the power differential is eliminated.

The second-order stance requires a different understanding of theoretical concepts, which sees knowledge of all kinds, including scientific knowledge, as a construction of the human mind (Scarr, 1985). This is evident in the vast differences in scientific concepts and explanations through time. Present science-shaking developments in quantum physics have certain implications for the theory of first and second-order cybernetics. Doherty (1986) explains that, according to quantum physics, the fundamental stuff of nature involves relations or connections. There are no enduring objects existing completely independently in time or space, and time cannot be measured independently of the inert frame of the observer, says Doherty. Therefore, the observed and the observer cannot be separated. Being and becoming are not opposed: they express two related aspects of reality. Doherty points out that quantum theory introduces the concept of probability which, applied to clinical practice, means that clients’ responses cannot be predicted with complete accuracy but only with some probability. The concept of interrelations between the observer and observed, complex causality and understanding the nature of process and change in quantum physics are, as Doherty observes, inherent in second-order theory.

According to constructivist theory, our knowledge is a constructed knowledge; but, says Scarr (1985), this fact should not disturb us, rather it should make our claims of scientific everlasting truth more modest. The disadvantage of the constructivist view is that we may feel less certain of what we are doing, which is an uncomfortable position for most people. The advantage is that our claims will be

more modest, but what is more important is that this position allows more space to address our ways of co-constructing (Scarr, 1985).

The second-order stance requires a different view on the process of understanding, where understanding in the new paradigm is a dialectical process consisting of circular and spiral relationships between the whole and parts, between the known and what is unknown, between the phenomenon itself and its wider context, between the knower and that which is known (Rowan & Reason, 1981). The knowledge we are seeking is not a thing we can have, but is developed through a co-construction in a personal, contradictory process of inquiry (Rowan & Reason, 1981). The truths are not impersonal but are attached very firmly to a person, a time, a place and a system (Rowan & Reason, 1981). Our understanding of the therapeutic process from the first-order perspective remains within the domain of the client's reality, hence simplistic, whereas the second-order frame intrinsically adds a dimension of complexity by including "how the observer and the observed are bound up with one another" (Becvar & Becvar, 1996, p. 81).

In addition, the second-order stance requires a fundamentally different view on how the therapist explains change in the therapeutic process. The dominant paradigm and first-order therapy promote a causality model of simple or linear causality where the therapist takes responsibility for changes in the client's system. Constructivism embraces the idea that an individual reacts not to the objective characteristics of the environment but rather to the way in which the environment is perceived (Fruggeri & Matteini, 1988). The therapeutic process is believed to involve the mutual influence of interacting individuals "whereby each transforms the other by being in relationship" (Becvar & Becvar, 1996, p. 335).

The new paradigm and second-order therapy prefer a circular or complex causality model where change is a result of a process that may be triggered by the therapist's input, but where the outcome is characterised and developed according to the client's own autonomy. According to constructionism, say Kenny and Gardner (1988), a person can only learn what his or her system is set up to learn. These authors, discussing the construction of self-organising systems, emphasise that because of a system's structure determinism, one system cannot determine or instruct the conduct of another because all changes that the system is undergoing are

determined by its own organisation. Thus therapeutic change can occur only when the client's interaction context changes in such a way that he or she will pay a lot of attention to the provocation of alternative structures introduced within the therapist-client interaction context (Kenny & Gardner, 1988).

We talk about development, say Skovholt and Ronnestad (1992), when change serves an adaptive function: it starts at a global level and moves to a more differentiated and integrated level; and it is qualitative in nature, not only quantitative. These authors propose that the therapist's development involves an individuation process which moves towards an increasingly higher-order integration of the professional and personal selves. Such development is impacted by multiple sources and over the long-term varies greatly. It often correlates with personal involvement, which can promote professional development (such as recovering from a dysfunctional family of origin, intense personal stress or crisis). Skovholt and Ronnestad conclude that the highest development in the professional self means that the personal self is well understood and integrated into professional life. They point out that stressful and difficult experiences are more beneficial and instructive than success and achievements. They also emphasise that a common major crisis for professionals involves lack of progress, which results in a searching process regarding the cause of failure. Skovholt and Ronnestad conclude that, with experience, the therapist's position changes from narcissistic to therapeutic, where he or she feels less powerful as an agent of change.

Moving from a first-order to a second-order stance requires a certain level of therapeutic development. These stances are therefore not two opposite positions but rather different positions which therapists move through in their professional development. The level of professional development when in the first-order position can be described as egocentric while the second-order position can be described as a therapeutic position. The dominant paradigm and the first-order position employ narrow models of understanding the complexity of human nature and consign interaction to a dualistic model of reality and linear causality, while the new paradigm and the second-order position offer a complex model of multiple realities and circular causality. The simplicity of the dominant paradigm means that in practice it is much easier to focus just on the client's reality, paying no attention to

the therapist. A second-order position involves increasing the complexity by adding the therapist's reality. The notion of co-construction adds even more complexity because we need to understand the client's system, then add the therapist's system and then look at the interaction between the two and how the therapist co-constructs with the client.

The dominant model of first-order cybernetics simplifies human nature and readiness for change by reducing these to something that can be manipulated by the therapist's interventions. The research process I have described here shows that emotional stress and initial failure perturbed me, as therapist, and promoted self-analysis. This prompted me to deal with the wounds inflicted in my family of origin, and with my marital difficulties. That process promoted personal development, where as therapist I became more real. The real person is more differentiated and able to feel unthreatened by someone else's reality (St. John, 1987). To be free to be oneself and comfortable with both one's negative and one's positive characteristics is much the same as having self-confidence. My struggle and developing ability to be real in personal life encouraged me to take a stance that was more collaborative, less judgmental and more inclusive of personal self, and enabled me to deal with the uncertainty of the therapeutic process without being instrumental and having a priori goals. All of this meant developing into a more mature personal self and subsequently a more mature professional self.

Examining the process I went through in moving from my initial first-order position to a second-order position, it strikes me that the amount of mastering in my own life paralleled the amount of fundamental change that such mastering promoted. For a therapist to let go of the secure position of objective theories, instrumentality and power, a fundamental change is needed in her or his approach to human nature and interaction. Thus second-order change leads to the development from a first-order to a second-order stance.

In order to get to a second-order stance one needs to go through stages of fusion and differentiation with regard to one's own theories, one's mentors and supervisors and their approval: fusion with one's own stance, believing it is the best one, in order to differentiate and take a more mature position which includes one's own and others' and allows the possibility of exploration and challenge. This

requires maturity of the personal self, which creates the space that makes it unnecessary to feel threatened by others' opinions. So the perspective of second-order cybernetics requires a personal and professional level of maturity that is developed in a long and emotionally exhausting process. But to get there, the therapist needs to make many fundamental changes regarding her beliefs, from letting go of certainty about her theories and fitting her clients into those theories, letting go of her power position and her expertise, to having the openness to create a context of discovery for others while still being open for her own change. This process requires second-order change, or a change in fundamental concepts. It is a life-long process in which the therapist never fully achieves a second-order stance in all the different aspects, since fully achieving such a stance requires perfection, but in which he or she can come closer to that goal.

The optimal development of the therapist is a slow, life-long process of attaining a maturity characterised by a synthesis of the professional and personal selves, which generates self-confidence, continuing self-evaluation, competency, creativity and personal liberation (Wendt & Dupuy, 1995). Personal liberation reflects maturity of the personal self and is a complex process where the therapist resolves the sense of disconnectedness with various parts of herself and her family of origin.

#### Implications for Psychotherapy Training, Supervision, and Continuing Education

In most countries, the usual way to become a psychotherapist is to obtain formal training, and most traditional training institutions (such as psychology departments at tertiary institutions) continue to focus on skills training and intellectual learning (Gilbert, Hughes & Dryden, 1989). Thus very few formal training programmes address the therapist's personal development and use of self and therefore very few are consistent with a second-order approach. Inclusion of the person of the therapist in training helps the trainee to master not only her technical skills but also the management of her personal self (Winter & Aponte, 1987).

The word supervision comes from the Latin "*super*" and "*videre*" which mean, respectively, "over" and "to watch" (Powell, 1980, p. 37). It is common practice for a therapist to become a supervisor after a certain number of years as a

clinician (generally 3 years, but where the need for supervisors is greater than the number available, less experienced therapists may become supervisors). On the one hand, supervision is considered a necessary part of psychotherapists' training, but on the other hand, training in how to supervise is limited (Watkins, 1997). Where it exists, such training is usually voluntary and is rarely provided by formal teaching institutions. More often it is the kind of training that is provided through continuing professional education.

The dominant paradigm and first-order therapy, and the shift to a new paradigm and a second-order stance, have made a significant impact on the teaching of psychotherapy as well as on the process of supervision. Describing the positivist approach to supervision, White (1992) comments:

It could be expected that any training and supervision that is informed by these ideas would place emphasis on the individual learning "correct" methods of evaluation, developing "precision" in diagnosis according to a system of constructed and approved "truths", and perfecting "known" and specified skills in the technology of interviewing; to subject him/herself to the teacher's/supervisor's expert knowledge. (p. 77)

Skovholt and Ronnestad (1992) describe four stages of therapists' development:

Stage 1: Exploration. Exploring different techniques, often feeling inadequate, sources of influence are professional; attempting to modify some of the externally imposed styles.

Stage 2: Integration. More personal style emerging, less rigidity, multiple sources of influence.

Stage 3: Individuation. Deeper authenticity, competent, increasingly oneself, individualised style.

Stage 4: Integrity. Authentic, acceptance of self, accumulated wisdom.

Supervision is mostly seen as an obligatory standard in the training of professional psychotherapists (Zorga, 1997). It has been recognised that supervisors also go through stages of development as they provide supervision (Blair & Peake, 1995). Heid (1997), in her review of different theories about supervisors' developmental stages, identifies Watkins's four-stage supervision model as the most comprehensive:

Stage 1: Role shock. The supervisor is acutely aware of weaknesses, struggles with anxiety and feelings of incompetence.

Stage 2: Role recovery and transition. Supervisor gains some perspective but still feels inadequate.

Stage 3: Role consolidation. Represents the supervisor's continued increasing confidence, greater utilisation of the process, more attention to the supervisees' needs.

Stage 4: Role mastery. Supervisor is able to take more risks, has greater flexibility, theoretical consistence and greater consolidation of different aspects of her self.

Professional therapists will begin supervising at the professional developmental stage, which coincides with Skovholt and Ronnestad's (1992) exploration stage, lasting 2 to 5 years after attaining the necessary formal qualification. The supervisors' transition stage parallels the integration stage of professional development. The supervisors' stages of role consolidation and role mastery both seem to fit into the professional developmental stage of individuation. We can speculate that if for some reason the professional starts supervising later in her career she is likely to proceed through the supervisors' developmental stages fairly rapidly because of the transfer of knowledge and experience from the professional to the supervisory context.

When we compare these stages to the first-order, first-and-a-half-order and second-order positions, we may describe the professional stage of exploration and the supervisory stage of role shock as first-order therapy and supervision. The professional integration stage and the supervisory transition stage may be said to correspond with first-and-a-half-order therapy and supervision. The professional stage of individuation and integrity and the supervisory stage of role mastery may be seen as compatible with second-order therapy and supervision.

Skovholt and Ronnestad (1992) discuss a psychotherapy teaching model that illustrates the learning process of trainees at different levels of experience. When one employs imitative teaching, or the jug-mug model (where one pours from the jug to the mug), learning occurs primarily through imitation of the supervisor. With didactic teaching the emphasis is on suggestions and demonstration. Corrective learning, where the supervisor assumes the role of the potter (who forms the unfinished piece of clay), places greater emphasis on correction, and as the therapist at this stage has more self-confidence, there is less focus on support. In creative

learning the supervisor assumes the role of the gardener (who prepares the soil for gardening), and the emphasis is on cultivating a context in which the facilitating function of the supervisor is conveyed. This last mode presupposes that the basic skills of psychotherapy have been mastered.

With regard to this teaching model, we may propose that a first-order position, characterised by objective interventions and the necessity of theoretical knowledge parallels imitative and correctional teaching. If we assume that people can only respond or promote a response according to their own level of self-organisation, it is likely that the first-order therapist has a limited capacity to use discovery methods. We may speculate that the first-order therapist has the capacity to use methods of suggestion and demonstration, assuming responsibility for the client's change in the therapeutic situation. The same would apply to supervisors functioning at levels 1 and 2, who may be unable to respond to trainees in a second-order manner.

Being collaborative, non-judgmental, creating a context for change without taking an instrumental approach, are all second-order characteristics which require creative learning of concepts that cannot be taught but need to be mastered. Not only does the second-order therapist master therapeutic concepts through a process of creative learning where the supervisor plays the role of the gardener, but the role of the therapist in relation to client has the same parallel, where the therapist plays the gardener by preparing the context for the seeds to grow but the outcome depends on the client's readiness.

In the discussion that follows I have used the concept of polarisation in order to achieve clarity in describing the differences between first-order and second-order supervision. However, it is important to keep in mind that, in reality, these two are not at opposite sides of a continuum, but are two developmentally connected perspectives of reality.

### *Supervision: Objective versus Intersubjective*

Positivism assumes the existence of reliable knowledge about the world (Jonassen, 1991), with the implication that first-order training and supervision consist of assimilating knowledge and the techniques of psychotherapy. Teaching is

goal-oriented and the supervisor uses direct instruction with trainees. On the other hand, as Prawat and Floden (1994) point out, constructivism claims that reality resides in the learner, who constructs a reality based on her experience and therefore also actively constructs knowledge. Each person therefore interprets the same information in the context of her or his own experience (Jonassen, 1991). This perspective calls for a dramatic shift in teaching from a traditional instructional style towards a more complex, interactive approach (Prawat & Floden, 1994). In respect of psychotherapy training, that would call for knowledge that is co-constructed between the trainee and the supervisor rather than reproduced.

Stolorow and Atwood (1992, p. 3) define intersubjectivism as “any psychological field formed by interacting worlds of experience, at whatever developmental level these worlds may be organized.” Post-modernism and social constructionism propose that intersubjectivity implies multiple truths rather than one truth (Jonassen, 1991). This suggests that training should be open and should put forward different alternatives rather than one point of view (usually the supervisor’s). The training process should be exploratory and discovery oriented instead of giving ready answers to trainees.

#### *Supervision: Instruction versus Co-vision*

The first-order position means that the therapist is a passive recipient while the supervisor is an expert who provides direct instruction, while the trainee implements what the supervisor instructs him to do. There is a power differential in the relationship, and the supervisor attempts to influence the therapist and teach him “her way”. The focus of training is on gaining expert knowledge, such as psychotherapy techniques, which would consequently make the therapist an expert who changes the client. This model places little or no emphasis on the training of the person of the therapist, as it is believed that the techniques and interventions are the most important components of the psychotherapist’s training.

In a second-order approach, supervision is co-vision, the process is collaborative and both therapist and supervisor participate in co-creating a context for learning. Knowledge is regarded as co-created rather than as learnt from preconceived theory (Bobebe, Gardner & Biever, 1995). In second-order training and

supervision the process of learning becomes reciprocal learning, where both parties are learning and changing.

Traditionally, evaluation of therapists' work typically involves a vertical hierarchy where the supervisor acts as control agent for the profession (Turner & Fine, 1995). In general it is only the trainee's performance that is evaluated. However, post-modernism and social constructionism offer a different view on evaluation. Evaluation that is open and transparent within a process co-created in a collaboration between the trainee and the supervisor is consistent with a second-order perspective. Evaluation should also become a reciprocal process, in which supervisor and trainee evaluate each other.

### *Supervision: Simple versus Complex Process*

The positivist approach to therapeutic training is simplistic in its assumption that each trainee is at the same level of knowledge and in its failure to take into account personal differences in experience, needs and styles. Social constructionism assumes that human learning is complex, and recognises multiple influences on the learning process. Therefore second-order training and supervision should address the complexity of the learning process by creating appropriate levels of difficulty for trainees' involvement. Such an approach creates a meaningful learning context for trainees, increases their motivation and secures emotional investment in the activity (Hickey, 1997).

A further dimension of complexity relates to the application of the positivist model of simple causality regarding the influence between the therapist and the supervisor. Post-modernism addresses the complexity and the conflicting paradigms by which we live and function (Hlynka, 1991), therefore post-modern training and supervision should create contexts where such complexity and conflicting paradigms may be explored.

In order to promote complex learning, trainees should be exposed to stimuli at different theoretical and experiential levels, and an integrated approach should be taken to work on the professional and personal selves. Trainees should be given the opportunity to develop autonomous thinking and to consider different consequences by self-reflecting on how different options would affect the self of the trainee and the

self of the client, and how the self of the supervisor would handle that. Such exploration would promote a questioning mode and an awareness of how complex and subjective human responses may be. Trainee and supervisor should explore their experience in supervision by using the technique of “being in the other person’s shoes”, which would also promote multiple understandings and an empathic relationship.

Psychotherapists are often exposed to ideas drawn from models that are quite different from those they encountered in their training, or they may work in close collaboration with professionals from other fields who use these different models (such as the psychiatric and medical models or the model used by sangomas or traditional healers). Instead of polarising these different approaches, the same technique of “being in the other person’s shoes” can be applied in respect of these different models. These models can also be included in learning through role-play (similar to exercises in which trainees are invited to explore the position of each member of a family, bearing in mind that members all occupy different positions of thinking and acting). Trainees should learn, through simulating the different environments in which the models have developed, to relate and understand such different perspectives as just another inter-subjective stance. Multiple stimuli, meaningful involvement and a democratic atmosphere of learning would therefore be basic conditions for including a complexity orientation in teaching.

#### *Supervision: Goal versus Process Oriented*

The first-order approach focuses on the product of teaching, and evaluation criteria relate to the assessment of the final product of teaching, such as the trainee’s therapeutic techniques or knowledge of theory. The second-order approach is not goal oriented, but process oriented (Jonassen, 1991), which means that training and supervision should focus on the process of knowledge as an activity involving the intellectual and emotional selves. The evaluation of trainees should expand the focus from the content of learning (theories and formal knowledge) to evaluating how the trainee learns about co-constructing (how trainees deal with conflicting therapeutic or supervisory experiences, with personal and emotional reactions, congruency of their verbal and non-verbal responses, dealing with negative feedback, and so on).

### *Supervision: Assisted Teaching versus Discovery Teaching*

The model of assisted learning is still the dominant model of teaching. Assisted learning, according to Hickey (1997), assumes that the student (or trainee) has a limited ability to make meaning out of the environment. The idea of discovery teaching comes from educational psychology (Slavin, 1986) and this model is based on the assumption that humans are inclined to explore, discover and make sense of their environment (Hickey, 1997). The discovery model applied to supervision in psychotherapy fits in with a second-order approach in its emphasis on active participation. The supervisor's role is no longer to instruct directly but to set up the context for learning. The process in the discovery method focuses on unfolding an emerging context. We can again compare this with the therapeutic context where discovery learning would mean setting up the context for learning rather than directly instructing the client. The supervisor creates such a context by doing the following:

1. Limits his or her ready answers when the trainee is struggling, providing instead appropriate questions that may be useful to the trainee in understanding the self-struggle.
2. Creates a safe and democratic atmosphere that will allow the trainee to explore alternative options even if they are very different from the supervisor's opinions.
3. Uses the example of his or her own humanity by sharing failures and changes that will allow the trainee to engage in exploration through a trial and error approach – a necessary road to discovery.

Finally, if we define knowledge as created through the transformation of experience (Kolb, 1984), then supervision should not be restricted to the exploration of professional experience but may need to go beyond that and be open to exploration of any experience which may be transformational in one's life.

As Whitaker (1989, p. 50) observes:

Nothing that is worth knowing can be taught. It has to be learned. It has to be discovered by each of us. The process of learning how you learn, of discovering your own epistemology – your method of handling discoveries, new thoughts, new ideas, new opinions – is something you must struggle for in order to evolve more and more of who you are.

Hickey (1997) points out that although the discovery model may be very creative and useful in teaching, such minimal guidance for the student (or trainee)

requires cognitively difficult work which may lead to confusion and frustration if the student (or trainee) is a beginner.

### *Supervisor: Knowledge versus Development*

The positivist approach focuses on increasing the supervisor's knowledge of skills, but little has been written on professional lifespan development and maturation of supervisors (Heid, 1997). Just as little has, however, been written on these topics from a constructionist point of view. As has already been discussed in this chapter, neither therapist nor supervisor is born with the ability to take up a second-order position, but develops such a position through a long and sometimes painful personal process. The second-order supervisor would have characteristics and abilities such as being comfortable with uncertainty, conflict and complexity. The ability to handle these without using defensive or protective mechanisms, which may interfere with the supervisory process in a negative way, requires a developmentally mature supervisor. I suggest that a supervisor who has reached the professional stage of individuation characterised by authenticity, accumulated wisdom, integrated professional and personal selves, and with 10 to 30 years' experience in the profession (Skovholt & Ronnestad, 1992), would have the appropriate abilities to develop a second-order context for supervision and teaching.

### *Supervision: Skills Training versus Skills Training and Training the Person of the Therapist*

Therapeutic approaches that parallel first-order cybernetics do not make allowance for inclusion of the therapist or his or her context. First-order training follows the same route, and training and supervision are technique oriented rather than self oriented. The second-order approach includes the therapist and his or her context (Hoffman, 1985), which has certain implications for training and supervision. This research emphasises the importance of including the personal self of the therapist in developing a second-order stance. A second-order approach does not exclude gaining formal knowledge and skills. Social constructionism promotes the inclusion of complexity in our reality; therefore instead of either/or we practise a both/and approach to first-order and second-order training and supervision.

The inclusion of the therapist relates to the competent use of self and self-disclosure in therapy, and training and supervision should therefore include the “person-of-the-therapist” in the curriculum. Competent use of the self depends on the general level of the therapist’s maturity, and the greater the level of differentiation of the personal self in the therapist’s family of origin, the more mature and competent the therapist’s professional self is likely to be (Bowen, 1978). The beginner therapist can greatly benefit from exploring the interface between the professional and personal selves in training and supervision. Work on the family of origin and the therapist’s awareness of the interface can greatly improve professional effectiveness and minimise the negative effects of counter-transference (Guerin & Hubbard, 1987; Kaslow & Schulman, 1987).

Framo (1979) believes that working on the family of origin is essential for therapists – so much so that he shared the experience of working on his own family of origin with his clients. Bowen (1978) used a method he called “person to person relationship”, whereby he encouraged trainees to relate to a person in their family without talking about others or about impersonal things. Bowen suggests that “if you can get a person to person relationship with each living person in your extended family, it will help you ‘grow up’ more than anything else you could ever do in life” (p. 540). One never becomes completely objective, but achieving a person-to-person relationship with close family members may make one a better observer and equip one to constructively use emotional reactions in clinical work.

Guy (1987) discusses the results of several studies which concluded that individuals who enter one of the mental health professions are likely to have experienced a high level of stress in their family of origin. Discussing the issue of the “wounded healer”, Guy reflects on different views about emotional difficulties, some of which hold that they are a handicap, and others that they are an asset for practising psychotherapy. Therapists who have worked on their unresolved issues with their family of origin are likely to be more effective in their clinical work because they can more comfortably move in and out of the client family (Framo, 1992), they do not look to their client families for approval and acceptance (Carter & Orfanidis-McGoldrick, 1976) their feelings are less distorted and react in a more therapeutic way to client families (Framo, 1992). Kramer (1980) explains that trainees who

(mistakenly) view their family of origin as healthy may overlook and minimise dysfunctional patterns in client families that resemble their family of origin, or on the other hand, trainees may misdiagnose when confronted with a family that is different from the family of origin. Trainees who have already dealt with certain issues in their own families are more likely to handle those issues successfully in client families (Framo, 1992).

Systematic work on the family of origin over an extended period of time yields positive results not just in the relationships within the family of origin, but also in the ability to deal more constructively with future stress, say Carter and Orfanidis-McGoldrick (1976). These authors believe that structured, long-term, personal family work, undertaken in small groups, should be part of the curriculum of the training programme as well as of supervision. According to these authors, clinical proficiency improves significantly among trainees who have done work on their family of origin.

Aponte and Winter (1987) conclude that the fundamental instrument, in any training model, for becoming a psychotherapist is the “person” of the therapist and that “despite one-way mirrors, personal psychoanalysis, videotapes, supervision, etc., it is a human person who is alone in a room with a client or a family” (p. 85). Aponte and Winter suggest that training programmes should include what they call external and internal skills. External skills refer to the technical behaviour utilised by the therapist in conducting a therapy session, while internal skills relate to the personal integration of the therapist’s own experience and self. They maintain that the therapist’s professional self should be congruent with the meaning and values of the therapist’s own life, which consequently stimulates his or her personal and professional growth.

#### *Supervision: Focus on “Resistance” versus Co-creation of Stuckness*

The dominant model in supervision focuses on the trainee’s issues and excludes the supervisor’s way of participating in the supervisory process. However, a supervisor who follows a post-modern approach participates actively by sharing her self with the trainee, and this provides a safe, trust-building context for learning. At the beginning of this chapter, I discussed the issue of responsibility for stuckness in therapy. In a first-order approach, it is the client who is responsible, while in a

second-order approach the stuckness is regarded as co-created. Applying the latter principle to supervision would mean that stuckness in supervision is co-created between the supervisor and the trainee, and that they are therefore both responsible for exploring and resolving the impasse. One of the most common reasons for stuckness in supervision relates to the supervisor's power position and the insistence that trainees must accept her idea or approach as the correct one. The most important factor in creating a collaborative, non-hierarchical environment in supervision is the supervisor's willingness to share and discuss her own personal and professional failures and difficulties.

Zorga (1997, p. 158-159) remarks that "learning is largely an emotional experience" and that "genuine learning is not an additive process, but a remaking experience." In second-order training, both the supervisor and the trainee engage in exploring painful processes, and this may perturb one's sense of integration and promote holistic learning. Holistic learning integrates perceiving, thinking, feeling and acting into one complex process (Zorga, 1997) and is consistent with a second-order approach in addressing the complexity of the learning process.

*Supervision: Major Source of Learning versus  
One of Many Sources*

The positivist approach focuses on supervision as one of the main sources of learning in psychotherapy. However, social constructionism believes in complex causality, which allows exploration and understands the therapist's development as multi-source influenced. The development of the second-order therapist would require the creation of many contexts, which would include different training levels of the professional and personal selves and work on differentiation from the family of origin. However, while these are necessary they are not sufficient to achieve this development. The complexity of the process of personal and professional change suggests that the impetus for developing a second-order stance derives from a number of different sources, ranging from the struggle with a personal crisis, to clients who are inspiring, to our own presence in therapeutic conversations (which have the potential to be a major source of influence and growth). In order to teach therapists how to teach others without being instructive, we need to develop more creative, discovery oriented ways of teaching instead of merely producing ready

answers for the trainees. The learning process should not abandon the first-order position but should include it along with alternatives that can awaken trainees' creativity.

### *Supervisor: "Perfect" versus Ever-changing*

The positivist approach assumes that in supervision it is the trainee who changes and is transformed, while the supervisor's hierarchical position suggests that she has already achieved perfection. However, this is not necessarily the case. A supervisor who takes a second-order stance plays a collaborative, participatory role and promotes reciprocal change that may transform both trainee and supervisor.

The interconnectedness discussed by Doherty (1986) in relation to quantum theory and its implications for psychotherapy encourages a parallel process in respect of therapy and supervision. Aponte and Winter (1987) make a number of observations about the therapeutic context, which I have adapted and applied to the supervisory context (where Aponte and Winter speak of clinician and client, I refer to supervisor and trainee) as follows:

1. The supervisor may need to risk and reveal himself to the trainee in ways that may not often surface in normal daily life.
2. The motivation to attain excellence in his own work is a powerful motivator in mastering personal patterns which can interfere in the supervisor's effectiveness with trainees.
3. The supervisor may need to generate considerable courage in order to face difficult issues which would be beneficial for trainees but that supervisor would not confront by herself.
4. Awareness that might otherwise have been avoided or hidden may be heightened through guiding trainees.
5. Moving into the pain in a trainee's life may lead to identification, which may allow access to similar pain in the supervisor's own life.
6. The supervisor's vantage point is a powerful paradox: while the supervisor is one step away from phenomena, he is at the same time intimately close to them through his bond with the trainee, which can lead to the supervisor being less defensive and more able to observe his own self.
7. Vicarious change, of which the supervisor's may not even be aware, may occur as a result of active participation in the trainee's change.
8. Special relationships may be created through supervision encounters, and may reinforce learning and the supervisor's own growth.

## Important Warnings and Recommendations for Training, Supervision and Continuing Education

There are several points that need to be remembered in promoting a second-order stance in therapeutic or supervisory relationships.

1. Engaging in continuing self-reflexivity. This research indicates that therapists and supervisors should take frequent inventories of the impact of their practice on their emotional and interpersonal functioning. Self-analysis promotes greater awareness of the interface between personal and professional, which improves professional effectiveness as well as personal functioning.
2. Inclusion of self. In order to become a competent clinician, the therapist's understanding of his or her self is a necessity. Trainees should be given tools and skills that will facilitate the acquisition of such an understanding (Halevy, 1998). It is suggested that the genogram is a potentially useful tool in the process of gaining self-knowledge. Work on the self creates greater understanding of the constructive and destructive use of the self and conditions which may promote such processes.
3. Taking care of one's self. Therapists (and supervisors) should learn to give priority to their own private lives and meanings; the fulfilment they receive from personal relationships will empower them to function effectively in the distress inherent in clinical practice, especially with emotionally disturbed clients (or trainees) (Guy, 1987). My experience suggests that it is vital that psychotherapists (and supervisors) receive nurturance and intimacy whether with spouse or friends. If these needs are not met, this may have a negative impact on their ability to remain emotionally available during clients' (or trainees') difficult moments (Piercy & Wetchler, 1987). Dilemmas, issues and ideas around taking care of themselves should be addressed in training, supervision and continuing education.
4. Issues specific to a psychotherapy career. Career satisfaction in psychotherapy is related to the pleasure of promoting clients' growth, but this also results in therapists' personal self-growth and feelings of personal competence (Guy, 1987). Charny (1982) points out some of the positives and negatives involved in practising psychotherapy. On the positive side, therapists are likely to become more human, more genuine and happier people as a result of the work they do. However, many therapists struggle with serious family and marital problems and a number have been divorced at least once (Charny, 1982). Our professional role demands that we understand more about the particular problems we face in our own lives. One of the hazards of a career in psychotherapy is that therapists may become trapped in building their professional self at the expense of their personal self, which subsequently leads to burnout and to professional and personal failure (Millon, Millon & Antoni, 1986). Some of the personal and family traps that, according to Charny (1982), we should be aware of are as follows:
  - Therapists often work too hard and leave too little energy for their own lives.
  - Having listened so many stories, therapists may find it difficult to listen to their own families.
  - Therapists tend to set high standards for their own family and marital functioning.

- Therapists are likely to develop more in respect of warmth, intimacy or fairness, and to tell his or her non-expert mate so. His or her mate may become resentful of this lesser status in matters of relationship.
- Human beings are almost never successful or competent in all respects in family life.
- Therapists inevitably find much satisfaction from the intensity of their professional work, but coming home to the family or mate who mostly operate(s) at the usual level of disconnection may create a position where therapists feel more, and more meaningfully, in and through therapeutic than personal relationships.
- There is a seduction in the professional role to superiority and a feeling of pseudo-wholeness attributable to the appreciation and affection of patients.
- The transactions of therapy take place on a different level than normal family life, for example in respect of commitment to growth and an unusual letting go of lies and airs, which do not apply when the therapist goes back to her or his own family life.
- In real family life there are normally times of regression, but for clinicians, overly concerned with growth, it may be very difficult to tolerate weakness and vulnerabilities in their own families and in themselves.

5. Personal therapy. The points listed above (Charney, 1982) make it clear why attending personal therapy may be of great benefit to therapists. It is surprising how little has been published in respect of the problems, weaknesses and regressions in therapists' own families and the "somewhat taboo area" (Charny, 1982, p. 52) of personal therapy for therapists. Because of the great emphasis on self-reliance and professional competence, there is an unrealistic expectation that healers need no healing, and therapists view themselves and are viewed by others as paragons of mental health (Millon et al. 1986). This atmosphere of intolerance for weakness prevents "wounded healers" from admitting to their personal and professional struggles and seeking personal therapy. Personal therapy can enhance therapists' empathy and genuineness with clients, increase their awareness of counter-transference feelings and generally improve their professional and personal functioning (Macran & Shapiro, 1998). Personal therapy, through dialogical conversations, (Anderson & Goolishian, 1988) promotes a context where the therapist co-constructs and co-invents her story, consequently developing a more complex narrative (Penn & Sheinberg, 1991). It is also an important qualifying and learning experience that makes considerable impact on the therapist's professional development, but by creating a climate of acceptance for our weaknesses we may reduce the risks of disturbing therapists' mental health (Charny, 1982). We need to be more honest about our professional and personal selves and to open ourselves to various interpersonal influences and life experiences. This will lead to a greater ability to access alternative options, which will stimulate fundamental change and moving towards the innovative orientation of a second-order stance. In the end, after all, "the only person a therapist can change is him or herself" (Anderson, 1997, p. 125).

6. Inclusion of failure. This research suggests that there is a parallel between the therapist's ability to deal with her failure in private life and interpersonal relationships and the way she deals with professional failure. The therapist's ability

to confront personal failure will, it is suggested, improve her ability to face professional failure and vice versa. A supervisor's ability to share failures with trainees will promote an atmosphere of collaboration, trust and active participation. It is, therefore, of great importance to expose trainees, in their formal training, to more formal explorations (e.g. through prescribed and recommended reading of the relevant literature) of issues related to failure, together with discussions and experiential activities that investigate failure and stuckness. The training of supervisors as well as professional continuing education should include a focus on this vulnerable side through discussions and work on professional and personal failure and the interface between them.

7. Inclusion of affective learning. Therapists need to develop tolerance and understanding of their own affective experiences in order to be able to facilitate clients' affective expressions (Jacobs, David & Meyer, 1995). Accordingly, learning to tolerate certain difficult emotional states such as anger and anxiety may be of great benefit to both therapists and supervisors. Professional training and supervision should build contexts that promote affective learning. Practising a position of curiosity about different alternatives may be helpful in building such context.

8. Learning to deal with the whole of human experience with all its complexity and paradoxes. Therapists are often confronted with aspects of human experience that have never been discussed or explored in their training, and as a result they may feel uncomfortable about discussing such issues when the client brings them into the therapeutic arena. Spirituality, religion and human sexuality are just some of the areas that are not usually covered in training, but if the trainee is to learn how to deal with the whole of human experience, these and other areas of life should be included in their training.

9. An important aspect of the ability to deal with the whole of human experience is flexibility. Flexibility can be taught or cultivated in training and supervision, and through workshops in continuing education. This can be achieved, for example, by using different approaches and promoting discussion on certain issues from alternative personal and theoretical perspectives. Such an approach would sensitise therapists and supervisors to the issue of "one truth" versus "multiple truths".

### Conclusion

The developmental process undergone by most therapists and supervisors is likely to start with a first-order stance. Depending on the level of perturbation, some may remain within the first-order paradigm while some would move through the transitional stage of the first-and-a-half-order stance. The greater the perturbation of the therapist or supervisor's system, the higher the level of development and growth achieved. Reaching the level of second-order therapy and supervision is likely to be a slow process that would depend on the individual's professional and personal experiences, crises, self-reflection and work on his or her own growth.

Finally, this research responds to several important missing links in the present literature:

1. There are minimal descriptions in the literature of what inclusion of the therapist means in the clinical context (De Shazer, 1991) and of how therapists' and clients' realities are co-created and changed in the process of therapy.
2. Steier (1991b, p. 179) proposes that instead of researchers' attempting to eliminate "emotioning" from entering into research, they should rather seek to understand it. This research investigates the effects of the researcher's "emotioning" on the "researched".
3. Most of the literature dealing with the first and second-order stances seems to reflect an either/or approach, thereby creating a polarisation between the two stances. This research takes a both/and approach, whereby the two perspectives are seen as part of a continuum of professional development. Development is seen as a process of individuation that moves towards a higher order of integration of the therapist's professional and personal selves (Skovholt & Ronnestad). The first-order stance thus represents a developmentally lower stage of this integration, the first-and-a-half-order stance represents a transitional stage where the therapist is moving towards a second-order stance, which is developmentally the highest order of integration of the professional and personal selves of the therapist.
4. This research proposes the use of a developmental model that integrates concepts such as the personal and professional selves of the therapist, first-order and second-order stance, and second-order change.
5. Finally, this research explores the implications of the positivist paradigm and a first-order stance, and of post-modernism and a second-order stance, for psychotherapy training, supervision and continuing education. It concludes with warnings and recommendations in respect of psychotherapy practice and supervision.

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