How to Survive as a Family Therapist

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This paper will look at the particular anxieties that a family therapist needs to manage to survive the work. Attention is paid to the clinical and organisational pressures that therapists need to be able to negotiate in order to work creatively. Some suggestions are made as to the therapeutic position which enables us to enjoy our work as therapists.

When Donald Winnicott made his oft quoted remark that 'above all the therapist should survive' (Goldman, 1993: 199, quoting Winnicott, 1969), he was speaking (in my understanding) of survival of ourselves as individuals in the fullest possible psychological sense: he meant that we should survive our own love and hate for our clients, and that we should also survive their wishes, demands, hopes, and disappointments in us, and use this survival to enrich our work. This experience, of course, does not happen without turbulence, but to deny the range of feelings people bring to therapy may be also to deny ourselves the richness of the experience. Conversely, to allow ourselves to be involved in our own experience may also be to allow ourselves to be curious and interested, in such a way that we may learn about ourselves and our clients at the same time. Not to do this risks exposing ourselves to the two occupational hazards of either chronic niceness or chronic cynicism (both of which perhaps originate in disappointment, in ourselves and in others). In this paper, I would like to look at the individual, family, and organisational dynamics that influence our survival as family therapists.

Failure to Survive: 'Burnout' and 'Stress'

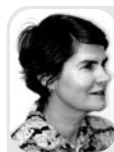
We often hear the term 'burnout'. It has always struck me as perhaps an overly catastrophic term to describe what is really the therapist's feeling of 'too muchness'. For instance, it is hard to say, 'I'm feeling a little burnt-out today' — it does not seem possible to talk about degrees of an absolute like 'burnout'. Yet the term does create an interesting image of a structure burnt out from within, perhaps a sense of a shell left standing. Surely this is the danger of clinical work, that it involves ourselves as people to such an extent that the professional self becomes a shell, not inhabited by a person engaging as fully as possible in a professional activity. Chronic niceness and chronic cynicism, referred to above, would both be examples of an uninhabited 'shell'.

Another term that comes to mind that is useful, but which also fails us, is 'stress'. In architecture or engineering, 'stress' is used in the context of evaluating the amount a load bearing structure can accept before reaching breaking point. *Emotional* stress is therefore understood to mean the experience of extra pressure, which carries with it the fear of 'overloading' one's psychic structure, culminating in a 'nervous breakdown'. However, nerves do not break down!

Perhaps ultimately the limitation of the concept of stress is its emphasis on impact from the outside. Although we can all identify with the notion of 'too much pressure', it is clearly not only the quantity of stress that needs attention, but the quality — what it means to us. For example, a full and busy day at work, with an accompanying sense of mastery, can be much more pleasurably experienced than contact with a single family who have left us feeling inept and stupid. Both 'burnout' and 'stress' carry with them the threat of a catastrophe. 'When anxiety is directed towards avoiding catastrophe, it is difficult to create enough space for surviving with enjoyment', as Nina Coltharts writes in *Surviving as a Psychotherapist* (1993:1).

> "the danger of clinical work, [is] that it involves ourselves as people to such an extent that the professional self becomes a shell"

The family therapy movement is now mature enough for therapists to include themselves as people in the equation of the therapy. This development (e.g. Flaskas & Perlesz, 1996) can be seen in the re-emergence of the psychodynamic concepts of countertransference and projective identification, in the form of thinking about and valuing the therapist's experience of the family as a way of understanding the family. This is a departure from the guru-led, technique-focused orientation that was evident earlier on in



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the family therapy movement. The focus on technique, although useful in training for skill development, often left people feeling that if they were not succeeding, it was due to a failure to employ the right technique. This, at times, was the equivalent of a belief in magic. An approach that allows us to reflect on failure as well as success may be essential if we are to sustain ourselves in consistent, thoughtful work.

Failure to Survive: Being 'Drained' and Being 'Put Into'

Therapists sometimes speak of feeling 'drained', as though their relating capacity is at some level diminished or 'eaten up'. Interestingly, Varma (1997) found that one of the most common stresses for therapists was having little time left for family, and finding difficulty in listening to the problems of their spouse or children. In this process, what is important is not only what is taken out of us by our work, but equally, what is put into us. This experience of feeling 'put into' is further described by Melanie Klein as projective identification. This is the phenomenon where one individual's unbearable experiences are projected into another and some identification occurs, so that the projection may be taken up unconsciously by the other person. We can most often recognise this when we find ourselves acting in ways that feel strangely uncharacteristic, or as Ann Alvarez says (1992: 2) 'Some people you meet always make you feel intelligent and attractive, while others always make you feel your slip is showing'.

This process may explain partly why the 'blame the victim' phenomenon can be so pervasive, in that on some level perhaps we all have the impulse to blame the client rather than, for a moment, feel the powerlessness of their position. We might attack the client psychologically, in order to protect ourselves from an experience of being like them. Without encouraging professional masochism, I am saying that on some level, being a therapist often involves bearing unbearable feelings for the client, and returning this experience to them in a less persecuting way. I will illustrate with a case from individual therapy before further illustrating the implications for family therapy.

> Anna is a single mother who initially came to see me regarding her difficulties in managing her daughter's lively behaviour. She sees me on an erratic basis. Anna has a complex history. When she was five years old, in first grade, her own mother failed to collect her one day, at the end of school. She was left standing at the school gate for hours, alone. Her mother never returned, and she never saw her again. She was brought up by her father, and subsequently her stepmother, to whom she was never close. A neighbour sexually abused her at the ages of nine and eleven. Normally, Anna will contact me in some distress, out of the blue, and we make a subsequent appointment. At the beginning of the session she will let me know how suicidal she is, how all alone in the world she feels.
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> At our most recent session, she told me, half laughingly, about a friend of hers who rings her each day to see if she's still alive. She describes her friend as feeling like she is hitting her head against a brick wall. I know well what that wall feels like against my head. I know that any attempts I make to credit her with her accomplishments (i.e. that she manages a full-time job, and has, over time, made friends whom she feels she can genuinely trust), any attempts to reassure her, only result in her reassuring *me* more strongly that she is suicidal. She helps me to understand that part of my job is to bear the horror, to stand my own feelings of powerlessness as well as hers, to allow her some sense of being alone, but together with me, in the session. She will often say during the time, 'I guess there is nothing anyone can do'. In one sense particularly, she is right, in that her survival depends on *not* doing, that is, it depends on resisting the lure of her suicidality. It also involves me in not doing too much. What needs to be faced is what cannot be done, in that history cannot be reversed and her mother cannot be made to collect her that day. Only if the hopelessness of this is faced between her and me together, is there some hope.
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> It feels to me that when she contacts me, Anna brings unconsciously her wish to live, which is projected into me in my role. It is a wish that, on some level, does not safely live within herself. When the timing is right, I've discovered that it is helpful to speak to her about the side of her that wishes to live, the side of her that contacts me. When I get it right, she does become more enlivened by this thought, and starts to think again about her own survival. Then she can think about how she can manage the destructive side of herself. She has awareness that to kill herself would do to her children what was done to her – repeat her mother's catastrophic disappearance. She is caught between the awareness of this and the compulsion to do it. Anna will frequently break off contact after what feels to be a good session. So, I am left abandoned, as it were, precipitously at the school gate. Although I wish the best for Anna, much of the time I'm having to manage what feels like her assault on my capacity to help her.

We all see very disturbed people like Anna. They are people who fill us with doubt and uncertainty, and at times make us feel furious, but essentially they do to us what they feel was done to them. Because of that, it is very important that these anxieties be contained in the therapist, who must find a position between doing too much and doing too little. Yet to remobilise her capacity to think about herself, to mother her motherless self may, in the case of Anna, be just enough.

Survival in Family Work

I would now like shift gears to think about the anxieties experienced specifically by therapists working with whole families, as opposed to individuals, and to formulate how issues to do with projection and relationship affect a therapist seeing a family.

Families' Fear of Blame

It appears that parents are almost universally anxious about being blamed for difficulties occurring in their children. Clearly this is a complex issue in that some families accept more responsibility than others for their children's difficul-

ties. Yet the emotional connotations of 'responsibility' and of 'blame' are quite different. The failure to acknowledge and deal with this anxiety can lead to a silent 'courtroom battle' occurring in the therapy room. As therapists, we may fail to be aware of this battle when we are more anxious to get on and do the therapy than to listen and find out what the experience of the referral was like. This may come from a wish to be technically focused, rather than to listen. In this case we are most often handicapped by our own therapeutic ambition. Recently, in seeing a family, I realised at the end of the session that such a battle had been occurring when the joking comment was made, 'Well, who's guilty?'

Such a comment can raise great anxiety for the eager therapist. A significant form of burnout that frequently occurs during the first few years of a therapist's work comes from failure to engage with the anxieties families may have in seeing us. All of us involved in the therapeutic endeavour can have a grandiose wish to heal. This may well blind us to the knowledge that families may dread seeing us. We may fail to acknowledge their dread, thus leaving them feeling 'unheard' and unwilling to come back. Or we may take their pain too personally, and feel 'burnt out' as a result. The answer to the comment 'Who's guilty?' may be 'No one', but we are all responsible for interpreting our own roles adequately.

The Need for Assessment

Making a clear separation between assessment and treatment is an important survival safeguard for the family and the therapist. As Beta Copley suggests (Szur & Miller, 1991), it is preferable to avoid using the term 'assessment' with families, because of its pass/fail connotations. However, the concept itself should not be lost. Unless we make an assessment of whether the family have some capacity to think in 'a relational way', to think interactionally, we may be asking more of them than they are capable of. At worst, a family whose culture is paranoid, blaming and persecuting, may turn the therapy into an arena of abuse. Sometimes, the only exit from this is to point it out,

> "a grandiose wish to heal… may well blind us…"

and then the family sometimes reunites around their hostility to the therapist. To avoid assessing whether the family is suitable risks the therapy being harmful. Where the family as a unit may not be suitable for family therapy, it may be useful to think about who is suffering the most, who is most worried; working with that person may provide leverage and impact on the rest of the family, as well as being more helpful to the individual concerned.

I would argue that all initial family interviews should be a respectful *consultation*, looking at what the family hopes for, what they expect, and what we can offer. All first contacts are in a way a form of pre-therapy contact. This model of consultation places the therapist in a freer frame of mind to be curious about the *wish* for therapy, as opposed to being caught up in the need to *do* therapy. I describe the assessment phase to the family as 'a time to meet together to hear everyone's point of view, and to decide where we go from here'.

The Referring Context: Therapists' Expectations

Therapists need also to reflect on their own expectations. Does the therapist come to the work loaded with expectations engendered by the referral information? At worst, the family therapist can be carrying the anger for the referring organisation towards the parents. In my experience, that form of projection can be more evident in hospital settings where there may be much more identification with the abandoned child, and much more anger with the perceived neglectful parents. Poppy Harris gives an example of this (2002: 67), when she is speaking of a workplace treating Aborigines with less respect than Caucasians. How do we find a neutral therapeutic position that allows us to be in the present with the family rather than in the future with our therapeutic goal — or in another room with our colleagues and their thoughts? It perhaps stands as a rule of thumb that the more open the discussion of the different agendas can be, the greater the possibility of making a workable therapeutic contract. Increasingly research (Dahl, Kachele & Thoma, 1988; Safran & Muran, 2000) is underlining the significance of the therapeutic alliance as an important indicator of successful outcomes in therapy. In a different context, the work of Laurie MacKinnon and Kerrie James with families in which there is child abuse (1991), describes the importance of negotiating the contract as openly as possible.

Supports for the Therapist – Co-therapy and the Therapeutic Team

Family therapy itself can be an oddly grandiose profession, in that I do think there is more call on the family therapist to carry some authority, to establish a place for having something to say, than in individual work. Christopher Dare (1986) psychoanalyst and family therapist, has spoken in the past of taking on the positive transference of a well-meaning grandparent. Yet if we are too anxious to take on this authority, this expertise, do we not risk earning the other meaning of 'expert', i.e. 'a drip under pressure'! Given the complexity of family work, it is important to 'not know' as much as to know. It is an interesting question how much the therapeutic team, when using the one-way screen, contains this sense of having to know everything. When it is working well, the therapeutic team can expand the possibility of new ideas that can be thought about with the family, and move away from the split between knowing and not knowing, to a position of trying to understand the complexity. Thus, the therapist is potentially freed from

trying to know everything. Of course if there is too much rivalry in the team, the reverse process will occur. There will be disputes as to who is the expert and who has the 'truth'.

Equally, having a co-worker with whom one has a 'worked out' way of relating is a very valuable achievement. The rarity of this achievement is understated in the literature except perhaps by Carl Whitaker.

Whitaker wrote:

> Co therapy is a complicated relationship much like a marriage. You have a contract that binds the two of you to trying to help the family, and you must evolve a relationship that includes room for both individuals to be themselves, yet provides some overall synchrony. It is important that both therapists like each other and that each brings a complementary interpersonal skill –one can be humorous, for example and the other can be more serious. It's also useful if the therapists grew up in families with different dynamics. This heterogeneous history provides a buffer against either therapist becoming overinvolved (1978: 285).

Yet, this achievement only happens when there is a commitment to working out the parallel process issues in the therapeutic 'couple'. 'Parallel process' is the phenomenon in which emotional conflicts in the family, conscious and unconscious, may be taken up and acted out by the therapeutic team or the co-worker relationship. This concept, which was originally psychoanalytic, has been reconceptualised by systemic theorists, for example Elkaim's description of 'resonance', where systems at all levels of a given hierarchy reverberate in sympathy (Elkaim, 1990: 130–142).

In general, the importance of colleagues to our survival can easily be overlooked, just as perhaps, in parallel, the sibling relationship is often overlooked in the survival of a child. Yet I would argue that 'unequal' co-working relationships can also be valuable to an experienced and less experienced worker for extending training opportunities. Given our professional knowledge of how people grow, how people learn, it is surprising how underdeveloped the notion of mentoring is in our profession. Mentoring is also the essential role of supervision. Is there a commitment in the individual and in the organisation to supervision, or is the commitment to 'keeping the blind spots blind' (see also Harris, 2002: 43)? I wonder if the resolution to this dilemma depends on the extent to which the whole organisation identifies as a therapeutic organisation?

Developing an 'Internal Supervisor'

Patrick Casement writes of developing an 'internal supervisor' (1985: 32). I have found this a useful capacity when working with families alone. To be able to wander away in one's mind, to take a 'broad angle lens' to the family for a moment, to see rather than hear what is happening, and for a longer moment, to let content flow by and look for process, to create another viewpoint, a third person's viewpoint, in one's mind. Poppy Harris in her evocative e-book, *Creative Encounters with Families* writes:

> I am not against theory or supervision. Both can be helpful. However what I argue against is any arbitrary or mechanical use of these which can blind us to our direct experience of the quality of interaction between client and therapist (2002: 43).

The 'internal supervisor' may be essential in creating a space to think. Casement says that when he feels particularly stuck with a client, he tries to imagine being in their shoes. It can be useful, when one family member is particularly annoying or provocative, to question how much they may feel stuck in that role.

Surviving and Dealing with Individual Differences in Motivation

Individual family members will always differ in their level of motivation for seeking help. David and Jill Scharf argue for using Ronald Fairbairn's intrapsychic term 'internal saboteur' in thinking about the role an individual may take on in a family, i.e. by sabotaging the capacity to be creative and to move forward. It is important to be mindful how much this individual may be bearing a projection for the family group. For example:

> **Mother:** Wayne didn't want to come today. He doesn't want to answer any more questions or talk to outsiders.
>
> **Therapist:** Perhaps it's difficult for everyone in the family to come along and bring what is personal in here to speak about.

The therapist must resist the invitation to marginalise Wayne in the resistant role. Of course this notion of the whole being greater than the parts and the idea that any individual may be 'speaking for' the whole family is primary to systemic thought too. The therapist's stance in the vignette above also reminds the family publicly that the task is in the arena of relationships. It is important to avoid humiliating or blaming parents, while still addressing the issues of parental responsibility. Byng-Hall writes:

> The family therapist who criticises overtly and covertly what a parent is doing in front of their children, or partner for that matter, undermines that parent's sense of being able to be a good parent, and what is worse denigrates his or her efforts in front of other family members (1995: 200).

This 'in front of' aspect must always be kept in mind by the therapist. What may be helpful confrontation with an individual may be humiliating and destructive in front of others. Byng-Hall (ibid.) noted that the process of change in family work is paradoxical, that it is often through the positive connotation of loyalty to a previous generation that parents are freed to change their own parenting practices. Family therapists carry a duty of care in a different manner to individual therapists.

Knowing When Not to 'Do Something'

For all of us there will be times when the nature of the suffering feels too great. On what feels to be a very fundamental, physical level, sometimes distressed feelings will pass through a family in therapy. Projectively, these

pass through the therapist as well. There may be a moment of feeling overwhelmed. Carmel Flaskas writes:

> Language is not always possible, and what comes to mark the experience is not so much how it is languaged, but how it is unable to be languaged. I am inclined to think that abusive experience which annihilates the self, or indeed threatens life, is always for a period unlanguageable. And in the first session … I come to have an experience which is for a time unlanguageable, though I then find myself having a physical reaction which forces me to think more about my experience and how to language it (2002: 189).

In some ways it is important to allow this to happen, and to perhaps reverse the old adage by 'just standing there', and *not* 'doing anything'. Although it is not for everyone, I know of no better road to survival as a family therapist than personal therapy — to know one's own vulnerabilities and distresses, to begin to know what is me what is not me. As Valerie Sinason put it, to be able to know how to 'manage one's own madness'. Or as Morris Whelan has said:

> … to people who say if you're in psychoanalysis or therapy you are looking at your own navel, I'd say, you are, you are looking at the sign on your body that you were originally attached to someone, that you got your life from them and that is how and where you actually started (1997).

How can we begin to work with families without unnecessary idealisation, contempt or avoidance, unless we understand our own ancestors, our roots, where we come from?

The Organisation and Survival

Organisational Defences against Anxiety

I would like now to look systemically at the therapeutic agency or organisation, and to think about how it may contain or frustrate the therapeutic process, thereby either sustaining therapists in their work, or contributing to their failure to survive. A useful concept first coined by Isabel Menzies Lyth (Obholzer, 1994) is the 'organisational social defense', that is the ways in which an organisation may function to avoid psychological pain. Her initial work was a hospital study, in which she noted that the youngest, least experienced nursing staff were those who had the most to do with the patients. The experienced nurses were rapidly promoted into administrative roles that separated them from direct work with patients, and from being able to support the trainee nurses directly. In turn, the trainee nurses' work was organised around tasks or wards, but not around patients. This was one way in which the organisation, perhaps unconsciously, created a structure where staff were split off from continuous emotional contact with patients.

A contemporary parallel would be the work of a Child Care Officer, a position, according to anecdotal evidence, with an average life span of eight months. Again, this work is generally done by the most inexperienced staff. Experienced staff are often promoted away into administration and policy. The most painful, dilemma-ridden work one can do in this society is left mostly to the youngest, least experienced workers. It seems that our own helping systems can have the equivalent of 'canon fodder' in armies. For there to be significant organisational change, there needs to be an attempt to value more highly the clinical frontline of therapeutic organisations. This may be connected to what many have always known, that the receptionist has a most crucial position in any organisation, and that the client's expectations and trust may be shaped as much by the atmosphere and morale of our organizations as by our own therapeutic capacities.

"It seems that our own helping systems can have the equivalent of 'canon fodder' in armies."

One could equally ask of the Child and Youth Mental Health Clinics whether waiting lists are a rational way of structuring client overload, or simply the organisation's way of avoiding people in distress? Innovations such as Clive Price reports in 'Open Days' (1994) are not only strategically useful concepts for handling the dilemmas of waiting lists, but demonstrate a form of emotional courage to work at the front line — not behind it. The open day concept is a strategy allowing families who normally would be on a waiting list to be seen for single session consultations on an Open Day. Innovations such as this can only be viable if experienced clinicians are also supported to remain in front line clinical work.

The organisation may mirror the struggles of its client population. It seemed to me that the traditional Child Guidance system, despite its good intentions, often functioned in a way that refused to allow the staff to grow up. Now that the organisation is named the Child and Youth Mental Health Service, the naming feels in some way symptomatic of the opposite anxiety; there is currently more manifest anxiety in our society about mental breakdown in young people, perhaps best highlighted by concerns about youth suicide. Perhaps we could now best be called 'The Keeping Madness and Death at Bay Service'.

It is useful to take a systemic, anthropological lens to our services, to look at the ways in which organisational rituals promote or frustrate the therapeutic task. Does the organisation function more like an enmeshed family, with too many meetings, unclear responsibilities and boundaries, or is it more like a disengaged family in which the organisational culture actually avoids any reflection on its external and internal relationships? All organisations would be situated somewhere along a spectrum between these two extreme positions. Do organisations mirror Deborah Luepnitz's concept of the family (1988: 16) — patriarchal

but father absent? Both therapists and management can contribute to management's potential absence of care.

The Health of the Therapeutic Team

How does the case conference help or hinder the therapeutic process? At worst, does it become a forum for grandiose claims of cure and failures that must be kept hidden? How can the case conference provide a forum for clinical anxieties to be contained within the clinical group? How can we create a culture where success and failure are looked at non-judgmentally, enabling us to learn from our experiences? How can different points of view be dealt with? Is the multidisciplinary team sometimes not concerned with the sharing of views from differing professional perspectives, but instead is simply 'discipline multiplied several times'?

Hinshelwood (1996) writes of the tendency for perceived 'differences' to become opposites. How can team members creatively hold the tension of different points of view, as opposed to seeming to grab for the truth? I am not arguing that therapists should become therapists to their own organisations, but rather asking how we can take a view that encompasses the psychoanalytic understanding of the unconscious and anxiety, and our systemic understandings of groups and organisations, and then work directly to resolve the ever-recurring institutionalised splitting.

Hinshelwood suggests that there may be some role for psychotherapists in looking at clinical and organisational anxiety by

> … trying to relate fears to reality, challenging omnipotent expectations of ourselves (or our patients), mutual support for each other with our feelings of inadequacy, and I suppose, as far as possible, a non-judgmental attitude to success and failure (1996: 22).

Outsider consultants may also provide the safety to 'hold' these anxieties productively.

Conclusion

In summary, the task of survival with enjoyment is a responsibility that needs to be held by the therapist. I would suggest that this can only occur with a sensitive and heightened attention to the complexities of systems. A realistic appreciation needs to include our own personal dynamics, as well as the complexities of others', including the organisation's. If the concept of resonance in systems (Elkaim, 1990) holds true, then if we minimise our experience of confusion and pain, we will ultimately minimise our clients' experience as well. In family work, the challenge is to achieve a point of view that encompasses many points of view: a position which allows complexity and openness would be an achievement for our organisational cultures, and for the families we see. It would also, I suggest, contribute substantially to our own survival, as family therapists and as individuals.

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