The Family Therapist's Own Family

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Approaches to family therapy and counseling are influenced not only by client needs and presenting complaints but also by the clinician's theoretical orientation and personal experiences. This article explores the reciprocal influence that takes place between family therapists, their families of origin, and the families they treat. The relative influence of these dimensions are explored from a systems theoretical perspective.

First there is a startling thump, then a scream, and finally an ominous silence. I (Jeffrey) look at the client sitting in my office, and she stares back at me forcefully as if to say, "Hey, this is your office. You go check out what happened." Not wanting to appear timid and indecisive in front of this new client, I take a deep breath and slowly make my way to the waiting room where I see an elderly couple, newly referred by a physician, in mortal combat. They are actually wrestling on my couch! The woman then stands over the frail-looking gentleman, clearly of superior physical strength, and proceeds to wag her finger in his face as she taunts him. He ineffectually tries to defend himself, finally hurling some accusation at her that long ago had been tested under similar conditions. His attack strikes its mark, for this dignified-looking, proper woman cries out in anguish and then proceeds to wail at him with her fist. On seeing me, the man and woman calmly composed themselves, rearranged their own (and each others'!) clothing, and then politely introduced themselves as the new couple I would be working with.

This couple and I were to spend many hours together during the coming months. Never could I have imagined the mutual effects we would have on one another. Naturally, I fully expected to affect them in a significant way by helping them stop their cycle of physical violence, but little did I realize the extent to which they would trigger my own family-of-origin issues or influence my own family relationships in the present. I had no idea that the abuse/violence I had witnessed in my personal life would help me with this couple as much as anything I had learned in graduate school.

THE PERSONAL AND PROFESSIONAL DIMENSIONS OF FAMILY THERAPY

Perhaps more than any other profession the practice of family therapy affords us numerous opportunities to integrate what we do professionally with our personal lives. Similarly, so much of what we have learned in our own families while growing up provides the basis for much of what we do as practitioners. In fact, we not only have permission to combine the personal and professional dimensions of our lives, but some also suggest that we have a mandate to do so (Kottler, 1992, 1993).

Every family or couple we see affords us the opportunity to examine our own family experiences. The elderly couple described earlier terrified me (Jeffrey) because they reminded me so much of my own grandparents and parents. I wondered, even though I have been happily married for 20 years, could this someday happen in my own relationship? Perhaps this couple lived without so much anger earlier in their relationship. Perhaps, despite my early decision not to repeat my parents'/grandparents' patterns of aggression, my resolve could give way only to have this cycle repeat itself in my life.

Another couple complains that they do not spend enough quality time together. They absolutely demand that they each arrive home every evening by 5 p.m. so that they can be with one another. As I hear myself tell them they might be a bit unrealistic in their expectations, I freeze inside as I realize how infrequently my wife, son, and I spend an evening, let alone a meal, together because of our respective overloaded schedules.

Every family we see can somehow remind us of our own family experiences. A young child complaining of feeling helpless may trigger remembrances of feeling lost or alone. Witnessing family members "take shots" at one another, trying their best to do some damage, may trigger memories when we bore the brunt of another's aggression.

This process of reciprocal influence that takes place in family therapy is multidimensional. Our lived family experi-

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ences join with those of the families we see in therapy to form unique, continuously changing templates about family life. Though we typically think of the therapist as the change agent, the reverse occurs, too, as therapy is a co-constructed experience. In the earlier examples, it was working with couples that renewed the therapist's commitment to his family. Family therapists also bring another ingredient to this picture of mutual influence: their professional training and theoretical allegiances.

Our theoretical metaphors are grounded in a systems perspective as well as constructs from several other well-known pioneer theorists such as Rogers, Adler, Sullivan, and Satir. We embrace several assumptions of first-order cybernetic thinkers: that individuals can be understood in the context of their intimate social networks (Amatea & Sherrard, 1994) and the suprasystem of which they and we are a part (D. S. Becvar & Becvar, 1996); that reciprocal causality or logical complements and recursive organization can explain behavior (Watzlawick, 1978); that systems seek stability, that is, a change in context encourages change in individuals and change in a member of a subsystem (family unit) invites other members of that unit to also change (R. J. Becvar, Canfield, & Becvar, 1997); and that attempts at first-order change based on linear logic often fail, whereas second-order change based on changes in the system (e.g., its rules, assumptions, framework) often makes for lasting change in the redundant, reciprocal patterns of family relationships (Watzlawick, 1978).

We are learning to incorporate higher order cybernetics (Keeney, 1982, 1983) and constructivism (von Glasersfeld, 1984) into our thinking about family therapy. Thus, we acknowledge that we actively construct what we believe as therapists and that our constructions reflect our schemas, narratives, and stories rather than a "true" representation of reality. Similarly, postmodern social constructionist thought reminds us that we are a part of, not separate from, our political/social system (Anderson & Goolishian, 1988, 1992; McNamee & Gergen, 1992). Our ideas and values are linked to the ecology of ideas of our society—to stories told and retold. Thus, we see the value of narrative and discourse as a vehicle in therapy (Dell, 1983).

With our theoretical metaphors on the table, so to speak, the next paragraphs will explore how we draw on these constructs to derive meaning from our personal life stories as they intersect with and reciprocally influence our professional work as family therapists. The premise that the personal and professional dimensions of our lives are inextricably linked sparks several conclusions.

Our within family-of-origin experiences affect our work with families. Most of us understand, firsthand, what it is like to feel scapegoated, triangulated, enmeshed, disengaged, punctuated, symmetrically escalated, or many of the other family dynamics that we look for as therapists. Having identified our own childhood roles of peacemaker, distancer, and distracter alerts us to those roles when played by our clients. Those of us who were subjected to some form of physical, sexual, or verbal abuse, or who suffered neglect or fused relationships, have well-refined stories about these experiences. Our stories, then, offer alternative ways of "languaging" about being a family member, including our solutions to stressful conditions. Our challenge is to search our repertoire of stories to find those that structurally couple or fit with our clients (Longino, 1990). Matched interventions can be as simple as a reframe or self-disclosure.

Family-of-origin issues not only provide us with valuable resources but can also be a source of our largest blind spots. For instance, one student trainee, who lost her mother to cancer when she was a young child, tended to infuse a story of maternal deprivation into the dialogue of each family with whom she worked. Another trainee, herself an ongoing sufferer of sexual abuse, asked to specialize in working with victims who have yet to express their rage toward their perpetrators, an act that she had not yet been able to complete. Still another trainee, who was smothered and overprotected within his family as a youngest child of eight siblings, tended to guide the families he worked with to disengage from one another to the point that autonomy was always emphasized over cooperation, regardless of the ethnic, cultural, or personal values of the members. Finally, a trainee who did not receive sufficient physical contact during his childhood often insisted that all his clients join together in a collective hug, whether they wished to or not. These examples of the student trainees with whom we have worked illustrate how attached we can be to our stories. In our view, stories with strong affect tend to be those that we hold on to most dearly. Also, stories without favorable endings tend to be in the foreground of our experience. Our blind spots can pose two major risks to our clients: We may infuse our "unfinished business" into their stories, and we may fail to join with them in any meaningful way, thus leaving their stories unchanged or at least not improved. This topic is often addressed as countertransference.

Koverola and Battle (1995) state that "the issue of countertransference is one that points most clearly to the influence that a therapist's own family experiences can have on the process of doing family therapy" (p. 324). Countertransference may be manifested in a myriad of different ways. Welch and Gonzalez (1999) argue that detached concern is the therapeutic view of helpers who are aware of and have come to terms with their own issues. This stance respects boundaries and balances compassion for the client with the needs of the therapist. They posit that therapists holding other views often fail to empathize adequately. Therapists who assume a detached or distant view often fail to appreciate the importance of the family's concerns. An example of this view would be a therapist who fails to acknowledge a wife's request for help from her husband in managing an acting-out teenager. Instead of offering empathy, this therapist might suggest that the daughter's rebellion was typical of her age

group, hinting that the mother was overreacting and the husband was appropriate in his unwillingness to help.

This view would be especially unhelpful for disengaged families where neglect is commonplace. Therapists who take too close of a view often depreciate or devalue helpees. They may argue with families or criticize one of its members. This view would be especially harmful to enmeshed families who enter therapy reluctant to trust the therapist. An inner view leads to overidentification with clients. Therapists with this view may loan families money, extend the length of sessions, or talk too much during the session. In a similar vein, Hayes et al.'s (1998) qualitative research uncovered three domains relevant to countertransference: origin issues, triggers (e.g., content of the session, therapists' emotions), and manifestations, which included categories such as approach, avoidance, and treatment planning. Research (Silverstein, 1998) shows that infidelity may bring up intense countertransference issues. Likewise, the impact of working with abused children can serve as a strong catalyst for the occurrence of countertransference (West, 1997). Our contention is that transference issues are best addressed by therapists who are aware of their family-of-origin experiences and their meaning. This self-awareness allows therapists to use countertransference issues in strategic, helpful ways.

The families from which we were spawned thus play a major role in the stories we tell ourselves and others. Our narratives affect our profession—the specialty we developed as family practitioners, the ways in which we work, and the clinical decisions we make. For better and worse, our own families of origin join us during every session we conduct with others. Yet, we have long wondered how it was possible for professionals to be highly skilled and successful family therapists when they are unable to apply what they know to their own lives. In fact, our culture is replete with stories about the "crazy shrink" whose personal life is marked with parent-child problems, marital strife, and the like. How is it that some professionals can teach the value of conducting family conferences, of facing conflicts rather than avoiding them, of showing compassion rather than exploiting others through power, when that same person operates in quite a different manner in their own personal relationships? We wonder if you share our experience of having known far too many professors and supervisors, supposed models for us to emulate, who espoused the importance of empathy and kindness, only to be rude and insensitive to others? We believe this discrepancy in personal-professional behavior is a manifestation of the importance of context, that is, that we have many selves, each choreographed differently, depending on context. Thus, the therapist is the professional who can be empathic in-session but may be the parent at home who is quite critical of her children. We believe this to be especially plausible when professional training makes no attempt to bridge personal and professional scripts. We also believe that being a part of an ongoing personal growth group experience for professionals may be a helpful way to harmonize home and profession.

Our current family experiences influence our work as therapists. A number of investigative teams (Guy, Poelstra, & Stark, 1988; Pope & Bouhoutsos, 1986; Thoreson, Miller, & Krauskopf, 1989) conducted research on which therapists are most likely to engage in inappropriate sexual relationships with their clients. It is clear from such studies that when professionals are undergoing divorce or separation from their spouses, they are more likely to act out unprofessionally. Similarly, therapists who are impaired by addictions, debilitating depression, life crises, and other traumatic family problems are less able to attend to their work with the same degree of clarity and competence than they could if their personal lives were in order. Gold (1999) contends that countertransference can only be understood when the events in the personal life of the therapist are considered.

When therapists have fights with their children, conflicts with their partners, or major problems in their families, it is difficult for them to insulate themselves from these difficulties in such a way that they do not affect the ways they respond to families who come to them for help. Just after learning my father had a stroke, I (Jeffrey) attempted to continue working with my clients as a way to distract myself from my pain. When I found myself insisting a little too vehemently that a daughter and mother kiss and make up, with tears of frustration in my eyes, I realized I was speaking more to myself than to them.

Just as our family-of-origin issues provide us with both ammunition and handicaps in our work, so too do our current family relationships equip us with resources to function more effectively. There is no more powerful ally in any session with a dysfunctional family than to draw on the strength of our own love relationships. Knowing, beyond any shadow of a doubt, that healthy family functioning is indeed possible—because we have helped to create such a sanctuary within our own families—is a potent vehicle by which to teach others to do the same.

Conducting family sessions affects our own family relationships. It is also not uncommon that our own family relationships are profoundly affected by what we witness during our sessions. There is simply no way that we could spend such intimate, intense, dramatic moments with people in excruciating pain and not be significantly affected by these experiences. It is virtually impossible to avoid being profoundly moved by some of the changes that we become part of.

Each day we complete as a family therapist we review a host of new things that we have learned—about the people we work with, about how families in general function, and about ourselves. For better and worse, we change in ways we could never have anticipated as a result of entering into the private worlds of other families. In some ways, we become more battle-scarred, more cynical and suspicious, more cut off from

our feelings in an effort to protect ourselves and our families, from human inhumanity. After all, we see people at their worst, when they are angry and wounded, when they are lashing out, when they feel helpless.

Sometimes, these experiences get the best of us. The realities of our clinical life at times almost seem to infect us like a contagious disease. When this happens, it is our stories that have been deconstructed, not those of our clients. Old stories that we thought we had long ago been resolved, replaced, or modified are revived. Finally, our clinical work sometimes get the best of us because we accept the cultural myth that professionals should be all-knowing and powerful. Who among us has not known families who we have not been able to help, yet such a realization is dissonant with our socially constructed belief that failure is taboo.

There are so many ways that our personal and professional lives merge together; it is at times difficult to determine where one ends and the other begins. Yet, we are also able to enhance our family relationships as a result of what we learn as therapists. Nobody else has greater access to what makes relationships work or fail than we do. No one knows as much as we do about how to recognize problems before they get out of hand and to do something constructive to change the patterns of mediocrity.

The personal and professional dimensions of being a family therapist are inseparable, just as our own families, in the past and present, join us in every session we conduct. Until we are able to capitalize more fully on our personal experiences to enhance our professional effectiveness, we will continue to feel crippled by what we have lived through. Until we can better insulate ourselves from the pressure and strain we encounter every day as we live with families in crisis, our own loved ones will suffer as a result.

The couple you met at the beginning of this article never did stop fighting with one another. I (Jeffrey) would like to think that before they left my care, they did learn a few ways to relate to one another with a bit more restraint and consideration. At least I taught them some alternatives to using their fists. For this, they should feel indebted to my parents and grandparents for having taught me so much about conflict.

Even after many years, my (Jeffrey) own family has been affected by the "gifts" left to me by this couple. I resolved then, and forever after, that I would never allow myself to stay in conflict with someone who I care for. I am trying hard to change the legacy that was passed on to me from my grandparents and parents, so that my son will grow up in a family in which he will never have known what is like for people who claim to love one another to act so cruelly. If I should neglect my resolve to integrate the personal and professional dimensions of my life, the next family that I see will remind me of how important it is to practice what I preach.

IMPLICATIONS FOR THE PRACTICE OF THERAPY

Based on the preceding discussion, we may conclude that our personal and professional lives, past and present, are dynamically interrelated to the work we do.

Our stories reflect the ecology of professional narratives that we have assimilated during our professional training and careers. Our professional stories span 20 to 30 years, and our treatment of clients mirrors the shifting zeitgeist of this period. Thus, we have encouraged clients to actualize, to rewrite scripts, to communicate better, to exchange rewards, to become less enmeshed, to differentiate, and to break recursive cycles of behaving. A common denominator of our attempts to help has been simply to encourage change—change, for example, in context, in perception, in behavior. A second ingredient has been the meta-communication to clients that our intentions were benevolent and grounded in the conviction that people can change for the better. Looking back, it was not our maps or metaphors per se that equipped us to help clients change; rather, it was our faith in those maps and metaphors plus our clients' trust in our good intentions that made for change.

Our past and current lived experiences with our own families reflect an ecology of ideas about how to be in relationships. Some of our stories read like a nonfiction how-to manual, for example, that rituals such as having a picnic for extended family on the Fourth of July maintain family cohesion. If these stories can fit our clients' frame of reference, they can be helpful. Some of our stories provide insight into developmental patterns that inexperienced parents are ill-equipped to understand. These stories provide the therapist with ideas about how to suggest reframes for the way clients' view their interactions with children and parents; similarly, they may help the therapist normalize presenting concerns. Some of our family-of-origin stories are incomplete. These may pose a problem if the therapist fails to appreciate their vested interest in having families rewrite the therapist's narrative. But if therapists assume a curious, not-knowing posture with families, co-constructed stories may be beneficial to both. Another example of personal stories that therapist-authors bring to therapy are those saturated with negative emotions. Most therapists probably avoid these stories out of self-defense. This territory forms the blind spots in the therapist's repertoire. It may be here that the therapist either fails to empathize (underreacts) or protests too much (overreacts). This is when co-therapy is most needed.

Our clients' stories change us professionally and personally. How many times have we offered our clinical hunches only to have our clients politely disconfirm our hypotheses? Over and over, we learn that our professional maps are not the

same as our clients' territory; moreover, we learn that maps must be revised because truth is relative, not absolute. Similarly, though families come to us for help, it has been our experience that most families have unique strengths. Often, parts of their narratives remind us what our stories lack.

Professional tales only influence the therapist's personal life if the professional mantra suggests they should and vice versa. Perhaps no theorist stressed the importance of the therapist as a person more than Carl Rogers (1951). Those therapists who have been schooled with Rogerian ideas tend to strive for professional and personal congruence. Psychoanalytic storytellers take this to a different level by requiring therapy as an integral part of training (Corte, 1995). First-order cybernetic theorists and positivists seem to believe that they are apart from that which they observe, so the professional and personal narratives are not necessarily bridged.

A major tenant of social constructionism that we embrace is the suggestion that reality is all made up, created and sustained by stories told and retold, and reflects an ecology of ideas perpetuated and sanctioned by society. We like this notion because it inspires hope. Stories are changeable and mutable. Thus, families with even the most hurtful of characters and plots can change. Therapists have the exciting opportunity to be a part of story making and remaking. Perhaps creative authorship is the essence of our professional and personal lives.

IMPLICATIONS FOR SUPERVISION

The ideal place to identify and work on personal issues triggered in our work is in supervision, especially the sort that helps us to examine countertransference issues that arise.

It would be helpful to ask yourself, privately or in a supervisory relationship, the following questions intended to work through struggles that evolve (Kottler, 1999):

- What are you expecting from your clients that they are unwilling or unable to do?
- In what ways do you feel guilt from unresolved personal struggles that parallel those impulses and emotions of your clients?
- How is your empathy impaired to the point that you find it difficult to feel loving and respectful toward your clients?
- In what ways are your inaccurate interpretations reflective of your own identification and projection processes?
- How do you experience feeling generally blocked, helpless, and frustrated with a particular family?
- Who do your clients remind you of?
- When do you feel bored or impatient with client progress?
- What does it mean when you have unusual memory lapses regarding the details of a case?
- How often do you have a tendency to speak about a client or family in derogatory terms?
- To what extent are you aware that you are working harder than your clients?

Clients tell their stories to helpers who are presumably empathic, trustworthy, credible, and caring. Countertransference issues can impede any of these ingredients. Like Welch and Gonzalez (1999), we consider it crucial to monitor your therapeutic stance. Are you too close or too distant? Are you too critical or supportive? Most important is the question related to the personal meaning of this chosen style: What does it say about your own unresolved needs?

Clearly, supervision is not personal therapy. We try not to be intrusive in this inquiry, but as the supervisor-supervisee dialogue proceeds we look for opportunities to help trainees confront their blind spots. To illustrate, when a trainee failed to confront a family about missed appointments, we asked her to envision what might happen if this breach of contract were openly discussed. She replied, "They would probably get really angry and tell me that the counseling wasn't working anyway because of my inexperience."

"So, their lack of commitment is really a failure of yours?" we asked. As supervision progressed over several weeks, with much reflection on the trainee's part, she began to see how and why she assumed too much responsibility for this family. This family's issues were close to home, reviving for her a time when she walked on tiptoes with an alcoholic father who was irresponsible and punitive when confronted.

Once the exploration (via listening or viewing tapes) and understanding (as in the above example) phases of supervision have been completed, we move to the planning and action phase of supervision. Working with a supervisee with a distant view, for example, might lead to collaboratively identified ways of becoming more caring such as appropriate touching. Some action plans are rehearsed during supervision; some are modeled by the supervisor, though we use this sparingly as supervisees can become discouraged if the supervisor's skills appear beyond their reach. The cycle of exploration, understanding, and action is repeated as new information surfaces from the supervisee's implementation of action plans.

The supervisor, as well as the supervisor of the supervisor, has his or her own unresolved and countertransference issues that arise. After all, as human beings who are imperfect, fallible, and have unique perceptions, we all are prone to distortions, denial, projections, and overidentification with the stories we hear, whether first- or thirdhand. We suspect if the reader was extremely honest with him- or herself, it is highly likely that a number of those reactions have been sparked throughout the reading of this article. This is both the plague and the gift of our work: We have the opportunity, every day, with every family we see, not only to help them heal their wounds but also to help ourselves heal our own.

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