Fam Proc 38:209-228, 1999

The Therapist's Inner Conversation in Family Therapy Practice: Some Ideas About the Self of the Therapist, Therapeutic Impasse, and the Process of Reflection.

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In this article, a distinction is made between the outer therapeutic conversation and the therapist's inner conversation. The therapeutic conversation is a circle of meaning in which both the therapist and the clients play a part. The therapist's inner conversation is described as a negotiation between the self of the therapist and his role. In this process of negotiation the therapist has to take seriously, not only his observations, but also what is evoked in him by these observations, that is, images, moods, emotions, associations, memories, and so on. Furthermore, therapeutic impasse is conceptualized as a paralysis of the circle of meaning and of the therapist's inner conversation. A process of reflection is proposed as a way out of the impasse. In that process, the inner conversation of the therapist is externalized with the help of an outsider. In the final part of this article, a case study illustrates the importance of these ideas for the family therapy practice.

> The only person a therapist can change is him- or herself.
>
> —**Harold Goolishian**[1]

The use of narrative metaphors like text, story, and conversation in family therapy developed out of a disappointment with the systemic/cybernetic metaphor as a dominant metaphor for family therapy (Anderson & Goolishian, 1990a). The way that cybernetic family therapy addressed serious problems of human relations and family life, such as violence, inequality, social injustice, and so on, was specifically attacked by many authors (Dell, 1989; Erickson, 1988; Goldner, 1985; Imber-Black, 1986). Erickson's critique (1988) was particularly devastating:

> None of the major human problems of our era can be adequately addressed by, or treated within, a systemic paradigm, whether child abuse, the situations of formerly hospitalized individuals, gender inequality, problems with spousal violence, or social inequality. Such problems either cannot be perceived within a systemic view (. . .) or, if attention is called to them, must necessarily disappear into a set of interlocking and circular relations, the sum of which are said to serve a purpose of coherence and fit, of being homeostatic and helpful, of being required by the family, of being wanted or desired. [p. 225]

The mechanical cybernetic jargon, the neutrality of the systemic therapist, his pragmatism, his expert position, and his reliance on objective observation were heavily criticized.[2]

It became clear that family therapy would benefit from new "metaphors to live by" (Lakoff & Johnson, 1980; Lowe, 1990). Most authors choose narrative metaphors (story, conversation, . . .) as alternatives for the cybernetic metaphor (Andersen, 1991; Anderson & Goolishian, 1988; Parry, 1991; Penn & Frankfurt, 1994; White & Epston, 1990). From a narrative perspective,[3] psychotherapy can be defined as a linguistic activity in which conversation about a problem generates the development of new meaning (Goolishian & Winderman, 1988, p. 139), or as a process of using subjugated knowledge to generate alternative and preferred stories that fit the person's lived experience (White & Epston, 1990). In this view, the client's voice and his lived experience are privileged since he is seen as the expert of himself. The relationship of the clients to the therapist is described as a relationship of co-authorship (White, 1991), participation (Hoffman, 1991), and collaboration (Anderson, 1997). Although it is clear that, in a narrative perspective, the therapist cannot claim an objective perspective, it remains unclear what is the place of the ideas, the thoughts, and the imagination of the therapist in the therapeutic conversation. If the therapist should take a "not-knowing" stance, does this mean that there is no room for his knowledge, his observations, or his ideas in the therapeutic conversation? If a collaborative relationship is preferred in narrative therapies, then what is the therapist's part in this collaboration? If the therapist has to follow the lead of the client, what does he have to do with his own ideas, hypotheses, and reflections? In other words, is there a place for

the person of the therapist in the therapeutic conversation, and, if so, what is that place?

Therapeutic Conversations and Not-Knowing

When a client seeks therapy, he has a story to tell (Epston & White, 1992; Gergen & Kaye, 1992; White, 1991, 1995; White & Epston, 1990). The story of the client is different, depending on the social context in which it is told. The story of the client is a selection of things told, and other things left untold. Of all the potential meanings, it highlights some things and leaves other things in obscurity. This selectivity depends on the culture of the therapy (Rober, 1998), or on the therapeutic context. In that sense, the story is a social construction (Anderson, 1997; Anderson & Goolishian, 1988, 1990a,b, 1992; Goolishian & Winderman, 1988): it has an always changing, evolving, and dialogical basis. Inspired by Gadamer (1988), Anderson & Goolishian (1992) describe the therapeutic conversation as a circle of meaning, of which both the therapist and client are a part (see Figure1). The story that emerges in the therapeutic conversation is co-created by the therapist and the client. The therapist co-constructs the client's story by the questions he asks, the positions he takes, the things he says, and so on.

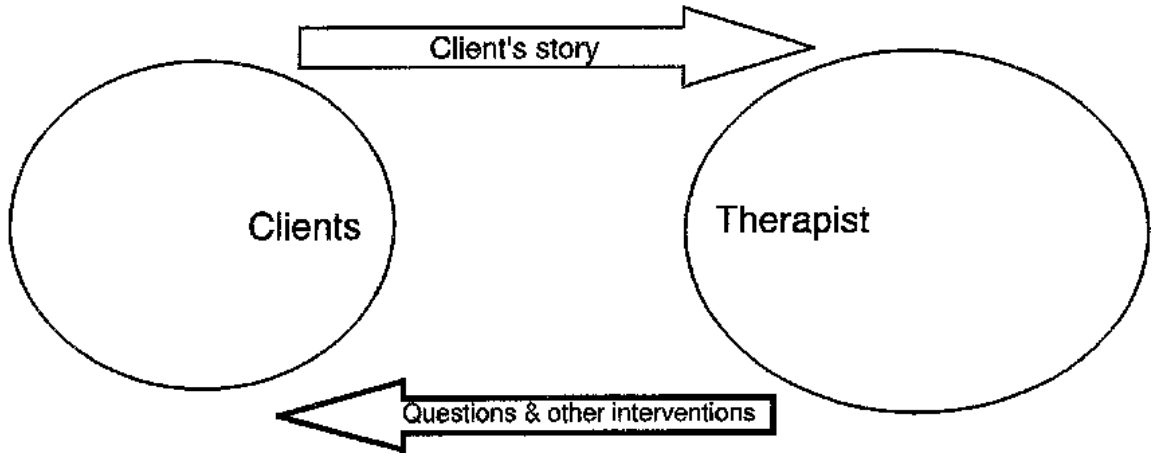

Figure 1.
The story that emerges in the therapeutic conversation is co-created by the therapist and the client.

In therapy, the therapist tries to help clients to tell their stories. He is responsible for the creation of a context in which the "not-yet-said" (Anderson, 1997; Anderson & Goolishian, 1988) can be said, or, in other words, for the creation of a safe therapeutic culture (Rober, 1998) in which subjugated knowledge can be accessed (White & Epston, 1990). This is a culture where the therapist is present as a person who has respect and empathic recognition for the stories the clients tell. By contributing to such a safe therapeutic culture, the therapist helps to make space for the "not-yet-said."

The therapeutic question is the primary instrument to facilitate the development of space for the not-yet-said. Anderson (1997), for instance, described collaborative questions; White (1991) distinguished between landscape-of-action questions, landscape-of-consciousness questions, and experience-of-experience questions; and Tomm (1993) speaks of internalized other questions. Besides questions, there are also other therapeutic interventions that can open space for the not-yet-said in the therapeutic conversation, such as story-telling, family sculpture, and so on. Needless to say, all these interventions have to be accompanied by the therapist's *connecting and collaborating stance* in order to open space for the not-yet-said (Anderson, 1997). Harlene Anderson (1997) sums up what she has learned from her clients about this connecting and collaborating stance in therapeutic conversation: The therapist's humility and uncertainty, but also his trust, his listening, his patience, his believing and validating the client's story, and so on, are important aspects of this stance (pp. 132-165).

The concept of *not-yet-said* refers to the client's internal, private thoughts and conversation (Anderson, 1997, p. 118) or, in other words, to the stories that haven't been told. This can be understood in a double sense. In the first place, the not-yet-said has to do with the stories that have never been told. Until that moment, words have failed to express the story; clients haven't yet found words for their experience. An example could be a mother who expresses her guilty feelings about the anorexia nervosa of her daughter: until she expresses them, they were part of the not-yet-said—that is, until that moment the mother didn't realize she had these feelings. In the second sense, the not-yet-said refers to a story that has already been told, but not in the present context of the family. The story exists in the system, but hasn't yet been told. An example of this is a family in which everybody knows the grief mother has about her father's death, but nobody talks about it. Family secrets are also a part of the not-yet-said in this second sense.

The role of the therapist in the circle of meaning can be described as being a "participant-manager" (Anderson & Goolishian, 1988) or a "participant-facilitator" (Real, 1990).[4] In a cybernetic epistemology, the neutrality of the therapist

wasadvocated (Selvini-Palazzoli, Boscolo, Cecchin, & Prata, 1980). In the narrative view, however, the therapist is a part of the system and the conversation is an I-Thou encounter between all persons engaged in conversation, including the therapist (Real, 1990). This is an aesthetic view (Keeney, 1983) in the sense that, being a part of the system, the humility of the therapist (Anderson, 1997) and his responsibility are of central importance: "Such a constructionist conversation demands at one and the same time the humility of a self-in-system perspective, the common sense to take personal responsibility for oneself within the system, and the political sense to acknowledge that social discourse is indeed social, not merely idiosyncratic" (Real, 1990, p. 260).

The therapist participates in the circle of meaning from a "not-knowing" position. "Not-knowing requires that our understandings, explanations, and interpretations in therapy not be limited by prior experiences or theoretically formed truths, and knowledge" (Anderson & Goolishian, 1992, p. 28). This description of the "not-knowing" position is influenced by the hermeneutical stance which states that there is no privileged position from which to observe reality (Anderson & Goolishian, 1992). The point is not that there is no reality (solipsism). The point is that there are several different vantage points from which we can observe the world, but there is no objective reference point (Parry, 1991). In this perspective, the question can be posed as to what we, as therapists, have to do with all our theories and all our knowledge if we have no objective criteria to evaluate their truth. Inspired by Neil Postman (1989), Lowe (1990) suggests that we think of family therapy's task as the development of cultural stories. He states that we should get rid of the notion that we are scientists, and accept the idea that we are among our culture's most important tellers of psychological and social tales. The purpose of family therapy should be "to put forward metaphors, images and ideas that can help people live with some measure of understanding and dignity" (Postman, 1989, p. 18). Indeed, if we cannot trust truth or science anymore, this doesn't mean we must live in an lawless, anarchistic world where anything goes and where there is no difference between good and evil. On the contrary, it means that values like dignity, responsibility, or equality are all the more important as ethical foundation on which to base our therapeutic practices.

Notwithstanding these philosophical and ethical reflections about "not knowing," in the daily family therapeutic practice the exact meaning of the concept is not self-evident. Anderson & Goolishian (1992) explain that a not-knowing position entails a "stance in which the therapist's actions communicate an abundant, genuine curiosity" (p. 29). This means that the therapist is open for anything the client says, and that he takes the story of the client seriously. Furthermore, this means that the client and the therapist together explore the client's story, his or her understanding and experience. Not-knowing means that the therapist listens in such a way that he is open to the full meaning of the family's descriptions of its experience. He doesn't search for regularities and common meaning that may validate his theories or his expectations, since that might invalidate the uniqueness of the clients' stories (Anderson & Goolishian, 1992; Parry, 1991).

Inner Conversation

Of course, the concept of "not-knowing" doesn't mean that the therapist's mind is a *tabula rasa*. As Anderson and Goolishian (1988) stated, the therapist maintains a dialogical conversation with himself, which is the starting point of his questions. In this article we will call thisdialogical conversation the therapist's inner conversation.[5] As the therapist converses with the clients he is simultaneously actively preparing and forming his responses (Anderson, 1997). Tom Anderson (1992) states: "When I talk with others, I partly talk with the others, partly with myself." He further maintains that the therapist's "inner" talk is about the ideas taking place in the "outer" talk, about the content of the "outer" talk, and about how the "outer" talk can best be performed (Andersen, 1991, 1992). Larner (1996) gives an example of the "inner talk":

> [I]n the midst of a conversation with a family concerning the child's detachted, rejecting behavior, the therapist may recall recent readings in attachment theory. The therapist could choose to share this "inner talk": that the child's behavior may be an attempt to maintain secure and close family relationships, particularly when recent loss has been experienced. [p. 426]

The thoughts, ideas, prejudices, and images of the therapist are opportunities to initiate dialogue on the condition that they are offered in such a way that conversation is continued rather than closed (Anderson & Goolishian, 1988). This means that one single idea of the therapist should not monopolize his inner conversation. This is what Anderson & Goolishian (1988) called a "mono-perspective": "In a mono-perspective, the development of new meaning ceases because one set of all possible sets of ideas dominates and becomes invariant" (p. 379). In the same vein, Fine & Turner (1991) speak of the tyranny of certain ideas of the therapist that would close any space for alternative ways of relating to self and/or others. All ideas of the therapist should be tentative, his thinking should be flexible, and he should entertain multiple views in his inner conversation.

These ideas of Anderson & Goolishian and of Tom Andersen about the therapist's inner conversation, though innovative and relevant, leave many important questions unanswered. They don't describe, for instance, what this inner conversation exactly entails, nor who are partners to the conversation, nor what the conversation is about. In this article I would like to

propose some hypothetical answers to these questions. Inspired by ideas about the use of the self of the therapist (see Andolfi & Angelo, 1984; Aponte, 1992; Baldwin & Satir, 1987; Haber, 1990, 1994; Real, 1990; Tilmans-Ostyn, 1990; Tilmans-Ostyn & Rober, in press), I will further elaborate on Anderson & Goolishian's ideas about the therapist's inner conversation and fill in some of the blanks. The ideas I propose—to be discussed at greater length—are summarized in the following three statements:

1. The inner conversation is a conversation between *two aspects of the person of the therapist*, namely, the self of the therapist and the role of the therapist.
2. The inner conversation is a *negotiation* between the self and the role of the therapist.
3. The negotiation is about what aspects of the self can be used to open space for the not-yet-said in the outer conversation, and in what way these aspects can be used.

The Self of the Therapist

Some authors state that in the therapeutic conversation the therapist uses his selfto seek constructive ways to work with the family (see Andolf & Angelo, 1988; Andolfi, Angelo, & De Nichilo, 1989; Baldwin & Satir, 1987; Elkaïm, 1989, 1997; Haber, 1990, 1994; Hildebrand, 1998; Real, 1990; Tilmans-Ostyn, 1990; Tilmans-Ostyn & Rober, in press).[6] However, the self is a controversial concept. Postmodernist and social constructionist authors are very critical of the modernist concept of self as a stable, autonomous essence of a person (Anderson, 1997; Hoffman, 1991). They propose a narrative view of self as an ongoing autobiography: "The self is an ever-changing expression of our narratives, a being-and-becoming through language and storytelling as we continually attempt to make sense of our world and of ourselves" (Anderson, 1997, p. 216). In the family therapy literature about the use of the self of the therapist, as well as in the context of this article, "self" doesn't refer to the modernist conception of the self, as a unitary, permanent, true core of the person, nor to the postmodernist conception of the self as "a stretch of moving history, like a river or stream" (Hoffman, 1991, p. 6). In this context, the self refers to the experiencing process of the therapist—in other words, to his feelings, intuitions, fears, images, ideas, and so on. The use of the self, in this sense, means that the therapist uses "his own personal responses in the form of images, moods and symbols in initiating and developing the therapeutic process. The therapist's observations and intuitions become elements of exchange and a constant source of information, with the creative imagination playing a central role" (Andolfi & Angelo, 1988, p. 244).

The statement that the therapist uses his observations, his intuition, his ideas, and his imagination as therapeutic tools to help the family, doesn't mean, of course, that in a family therapy session the therapist says whatever comes to mind. Indeed, before he does anything, the therapist, in his inner conversation, has to reflect on *if* and *how* he can use the elements of his self to promote a healing conversation. To gain more insight about this inner conversation, I will make a distinction between the therapist's role and his self (see Haber, 1994). The *self* refers to the experiencing process of the therapist and reflects the therapist as a human being and a participant in the conversation. It refers not only to his observations (what the therapist sees or hears), but also to his imagination (the emotions, images, associations, and so on, that are evoked by his observations). The *role* of the therapist reflects the therapist as professional whose task it is to facilitate the conversation. The role refers to the therapist's hypotheses and his theoretical knowledge. These hypotheses aren't focused on the family functioning (communication, structure etc.), but on the therapeutic conversation. The therapist makes hypotheses about possible ways to open space for new stories and meaning in the therapeutic conversation. Furthermore, theoretical and scientific knowledge is viewed from a postmodernist perspective and considered not as truth but as scientific stories (Paré, 1995). These stories can be used as resources to therapists for developing hypotheses that can eventually be introduced into the conversation. In that way, the range of alternative decriptions can be expanded.

The distinction between role and self isof course artificial, and it probably doesn't correspond to any ontological reality. It is, however, a distinction that proved to be very useful for me in the daily practice of therapy and helped me to understand what I was doing in the therapeutic conversation. Also in supervision and training, it is a useful distinction. Supervisees and trainees usually experience it as clarifying and helpful, especially because they feel their person, their creativity, and their imagination are given an important place in the therapeutic process in a safe, professional way, and without falling in the trap of amateuristic, wild therapy with all its iatrogenic risks. However, the distinction between role and self can also be confusing. Cooklin (1994), for instance, understands the concepts of "self" and "role" as oppositions. He understands the concept of "self" as a unitary, true core of the person, and the concept of "role" as something that is more superficial and artificial. Indeed, it is important to keep in mind that the concept of "self" in this context doesn't refer to a true core of the person. It refers to an experiential phenomenon, namely the observations, the images, intuitions, ideas, and so on, that the therapist experiences during the therapeutic conversation. In the same way, "role" doesn't refer to a superficial façade, but to a genuine aspect of the personhood of the therapist. When self and role are described in this way, there doesn't have to be an opposition between self and role of the therapist—although sometimes there is.

Process of Negotiation

When we make the distinction between self and role of the therapist, the question this poses is what is the relationship between these two aspects of the person of the therapist in the therapist's inner conversation. Haber (1994) states that the self of the therapist can be an effective consultant (and not a supervisor) to the role of the therapist. Accordingly, a therapist should listen to his self, but he shouldn't act unless his self fits with the context of the session: "The self can generate information and images; the role needs to decide whether and how to use the information" (Haber, 1994, p. 279). In other words, during the therapeutic conversation, the therapist is engaged in an inner conversation about the ways he could use his self in therapy in order to facilitate the conversation. This inner conversation can be described as a dialogical process of negotiation between the self and the role about the actions the therapist should take in the outer conversation (see Figure 2). As Real (1990) puts it, in his inner conversation the therapist reflects on the question "How may I position myself vis-à-vis the many contrasting currents in this system, its multiple realities and agendas, in such a way as to promote healing conversation?" (p. 260).

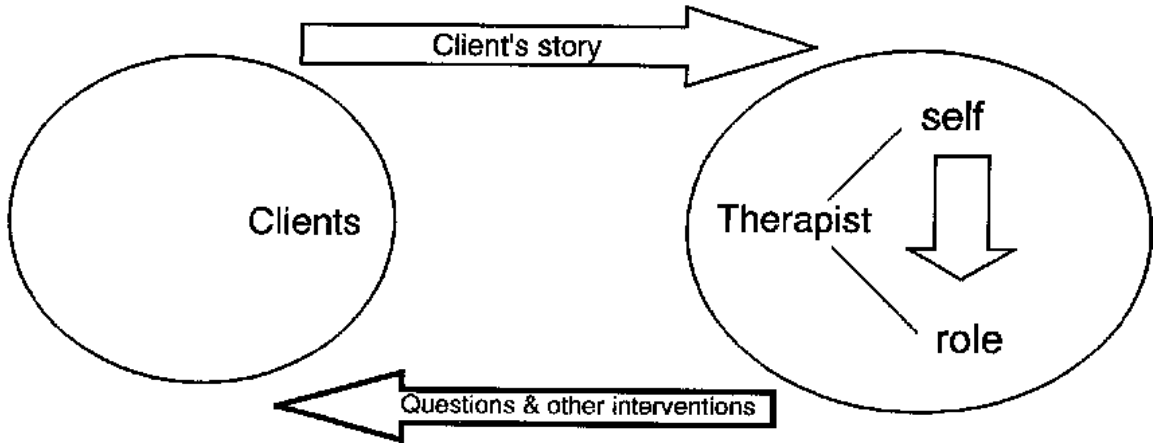

Figure 2.
The dialogical process whereby the therapist negotiates between his self and his role as to what action he should take in the outer conversation.

In this process of negotiation, the therapist has to take seriously not only his observations but also what is evoked in him by these observations—images, moods, emotions, associations, memories, and so on. These aspects of the self are often neglected by therapists (Tilmans-Ostyn, 1990; Tilmans-Ostyn & Rober, in press). There are a lot of possible reasons for this negligence: the things that are evoked in the therapist by his observations can be strange or bewildering, or they may, at least at first glance, not fit the theories or the expectations of thetherapist, or they may be scary or shameful for the therapist or for the family, and so on. In these cases, therapists might dismiss these aspects of the self as unimportant, uninteresting, or irrelevant. This is often a missed chance, because the self of the therapist, especially those aspects of the self that the therapist at first glance doesn't really understand or that scare him, can be a rich resource for the therapist and for the therapeutic system since they can give access to things that haven't yet been said. Haber (1990) states that "the therapist's personal reactions are keys to use to enter and understand the analogic, relational, and symbolic processes within the client and therapeutic system" (pp. 376-377). Elkaïm (1989, 1997) also values the personal experiences of the therapist as a therapeutic tool, and he stresses the importance of the context in which feelings arise. What members of the therapeutic system experience does not come only from that person's personal history, it is also amplified and maintained by the context. Elkaïm (1997) speaks from a systemic/cybernetic perspective when he states that the importance of the therapist's personal experience lies in its meaning and function for the therapeutic system: "[I]n the same way that for the systemic therapist the identified person's symptom has a meaning and a function in the family system, I hold that the feelings that arise in any member of a therapeutic system have a meaning and a function with respect to that therapeutic system" (p. 163). From this perspective of the therapist's self, we can say that it is often better when the therapist not only *listens* to the clients story, or *looks* at the story they tell in a nonverbal way, but also *feels* what is happening with the client as a person. The therapist has to be in continual contact with his experiencing process, and he has to accept his feelings, images, intuition as meaningful, even if he doesn't understand the meaning of them (Rober, 1998). Furthermore, he has to ask himself how his observations and the things that are evoked by these observations might be meaningful for the therapeutic conversation. This means in particular that the therapist has to reflect on *if* and *how* his self can be used in a constructive way in his role as therapist so as to open space for the not-yet-said. As Real (1990) puts it:

> Guiding the therapist's use of self is the principle of "usefulness," What is the feedback to the position one takes? Are systems members moving closer toward the therapist and toward one another, or are they pulling away? Is the conversation opening up into greater variety and experimentation; or is it constricting, moving deeper into rigidity

and monologue? [p. 270]

These ideas about the use of the therapist's self are illustrated in the following case examples.

Case Example 1

The first session with a family with an adoptive child of 14 years old, was a very pleasant session. There was an open atmosphere and a lot of laughing. Still, I felt an uneasiness. Although we had already talked about the adoption, I found myself hesitating to ask about the biological mother of the adoptive child. In my inner conversation I asked myself:

> What happens here? . . . Do I usually hesitate when I want to ask an adoptive child about his or her biological mother? . . . No, usually I don't. . . . What might it mean that I hesitate now? . . . What might be the risk of talking about the biological mother of this child?

When I shared these reflections with the family, the mood of the child changed from playful to angry. She said that her biologicalmother had sold her to her adoptive mother for a lot of money: "I hate both my mothers," she said in a disgusted tone.

The atmosphere in the session had changed drastically, and I understood that my hesitation to ask about the biological mother came from the child's underlying anger, which had now became evident. I must have sensed it somehow, and had hesitated to spoil the enchanting, pleasant atmosphere of the session by starting to talk about this difficult theme. Needless to say, the rest of the session wasn't as pleasant as the first part, but we managed to talk about the child's feelings of abandonment and alienation. The next session the girl said she was relieved that I had given her the opportunity to be angry.

Case Example 2

A couple came for therapy because the wife didn't feel understood by her husband. In the first session, the woman explained that she was a psychologist herself, but she had stopped working 5 years ago. She told me she had had a sexual relationship with her supervisor, but when she wanted to end that relationship, he had raped her violently. The supervisor had refused to talk to her afterwards, and he also refused to read her letters. Although her husband knew about the extramarital affair and the rape, she didn't want to talk about it with him "because he doesn't understand me," she said. For the past 5 years, she had been unable to work because she couldn't concentrate, and she suffered from severe anxiety attacks and psychosomatic pains.

While she was telling me her story, I felt very uneasy because, although we certainly weren't friends, I knew the supervisor she talked about. He had been my colleague years ago. I hadn't seen him for some time. But that wasn't the only reason for my uneasiness. What was most unsettling was that when I looked at her, at the movements of her hand when she scratched her forehead, at her tormented facial expressions, and when I heard her slow voice and her heavy sighs, I saw my ex-colleague. She moved in the same way, and she spoke in the same way, as if he had invaded and possessed her body, as if he had bewitched her.

I found it difficult to share my reflections with the couple. In my inner conversation I asked myself if my observations maybe were influenced by some unfinished business I might have with my ex-colleague. I didn't think so. I wondered also if it might be helpful for the couple if I shared my reflections. I didn't know, but I didn't think it could do harm, so I decided to tell my clients what I had been thinking. I told them I felt very uneasy because when I looked at her it was as if the supervisor were here with us in the room. I explained how I saw him in her movements and I said, "It's as if you are possessed by him."

The husband was astonished and said that those were the exact words he had used to describe how he had experienced his wife over the last few years. The wife, however, was angry. She said I must have talked with her husband on the phone about it before the session. This was not true, however. During the first phone call, I had talked only with her.

In the following session, the woman apologized for her anger and said she now realized that for the past 5 years she had defended her supervisor. She realized that she had always been loyal to him by refusing to talk about the rape with her husband, as if by keeping the secret of the rape she still had some exclusive relationship with her supervisor. Now she wanted to talk about the rape in therapy and she planned to take steps so that the supervisor would never again abuse any of his trainees.

Case Example 3

A mother came for therapy because her husband had left her. She had to manage on her own with her two children. One of the children was asthmatic and needed special attention. The mother said that her husband had left her for a younger woman and that hurt her very much. While she was telling about her pain, I felt as if she were keeping me at a distance in some way. I noticed that whenever I gave an empathic comment ("That must have been painful for you") she said

something that felt as if she wanted to keep me at bay ("Of course it was painful. What do you expect?"). I felt as if she asked for my help, but at the same time kept me at a distance. At that moment I saw an image of a white wolf in the snow. The wolf was hurt badly; the snow was red from the blood.[7] I asked myself what I could do with this image. Would I just share it with mother, or do something else with it? Then I thought that I could elaborate on the image and make up a story about a white wolf. I asked mother if it was okay with her if I told a story. I explained to her that I had a strong image which might mean something for us in the therapy. I told the story about two Indians who were returning from a hunt: "It was winter and the trees were covered with snow. When the Indians approached the river, they heard the howling of a wolf. . . ."

The story is about a white motherwolf and her wolfpups who were attacked by a grizzly bear. The motherwolf did all she could to defend her pups. She succeeded in drawing the bear's attention, which gave the wolfpups the chance to flee to the safety of their den. But in the struggle, the bear wounded the motherwolf with a blow of his big forepaw. Although she was bleeding profusely, the motherwolf managed to escape and the bear followed her. The Indians had seen it all. They admired the brave white wolf and they knew that she had tried to lure the bear away from the wolf den. The Indians wanted to follow the brave wolf because she was wounded and wouldn't survive without help. They followed the tracks of the wolf and the bear through the snow and soon saw that the bear had given up the chase. The Indians ran faster to catch up with the wolf. The wolf however ran farther and farther because she heard she was being followed and she thought it was the bear. The Indians ran several miles, but they didn't seem to get any closer. The next day, the Indians found the dying wolf. Their help came too late.

After I had told the story the room was silent. Then the mother said "I don't understand what you mean exactly." I answered that neither did I, but I wondered if the story might mean something for her. We talked about it some more until mother said, "I realize now that in some way I'm afraid that if I start to need your help, you might leave me as my husband did. Maybe that's why I keep you at a distance as the white wolf did." I said I also had learned something from the story. I understood now that I had chased her away with my attempts to help her. Later in the therapy the image of the white wolf returned several times. One time for instance, mother explained that she had learned in her family of origin to distrust offers of help: "In fact, we are a family of white wolves," she said.

Discussion

The above are three examples in which the self of the therapist—that is, his observations and the things that are evoked by these observations—is used in therapy. These examples also illustrate some of the ways in which aspects of the self of the therapist can be introduced intothe conversation. As illustrated in the first example, sometimes it can be helpful for the family when the therapist just shares his reflections in a tentative way. This is what Anderson (1997) calls "going public." Other times, the use of metaphorical communication is indicated (Tilmans-Ostyn, 1990), as illustrated in the second example where the therapist uses the metaphor of being *bewitched* and being *possessed.* In the third example, the therapist's mental image of a wounded wolf was used as a starting point for the telling of a story that proved to be very meaningful for the therapeutic conversation.

If we take a closer look at this process of the use of the therapist's personal experiences in the therapeutic conversation, we can distinguish three stages (see Figure 3) in the inner conversation of the therapist (Rober, 1998):

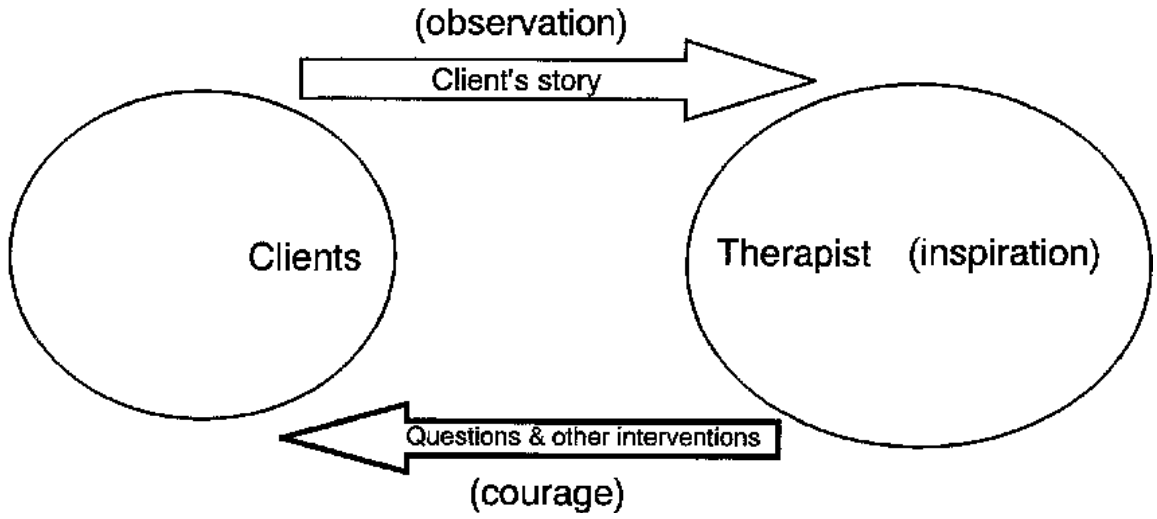

Figure 3.
Three stages in the therapist's inner conversation: inspiration, courage, and observation.

1. The first stage, the stage of the *inspiration,* is mainly intuitive. The therapist is open to his observations, his intuition, his personal affective responses, and his mental images. He then searches for a constructive way to use them in the conversation so that a space is created for the not-yet-said.

2. In the second stage, the stage of *courage,* the therapist proposes his response to the family. He translates his inspiration into action. To do that he needs *courage* because he takes a risk by responding intuitively in a situation where his the meaning is unclear and he cannot know for sure how the clients will react.

3. In the third stage, the stage of *observation,* the therapist observes how the clients react. Do the clients start to speak about something meaningful that hadn't been said yet? Did his response create more safety in the conversation, or trust in the therapeutic relationship so that the telling of new stories becomes possible?

There are of course some dangers in following one's intuitive inspiration as a therapist (Elkaïm, 1997). The most important danger is that the therapist might attribute his personal experiences during the session to the family or to something that happened in the conversation, while the experience may actually have some source in the personal life or history of the therapist. For instance, a therapist who feels sleepy during the session might attribute this to the benumbing boredom and depression he observes in the family, while his sleepiness could in fact have a more personal explanation. It is clear that elements of the therapist's self should not be introduced in the outer conversation without some critical reflection by the therapist. It may be useful to make some practical recommendations concerning the use of the therapist's personal experiences in the outer conversation. Inspired by Elkaïm (1989, 1997), I would like to suggest four steps in the therapist's inner conversation during the stage of inspiration:

Step 1. The therapist accepts that his personal experiences arising in conversation with the family are not meaningless or coïncidental. They may be a result of his personal story, but they are also evoked and shaped by the social context in which they arise (the outer conversation).

Step 2. The therapist is skeptical about his experiences and asks himself:"Are my experiences more connected to my own personal story than to the context of this conversation?" If they appear to be very much connected to his own story, and not so much to the social context, they shouldn't be introduced in the outer conversation. It might be useful instead to talk about these experiences with a colleague or a supervisor.

Step 3. The therapist formulates hypotheses about ways in which his experiences might be meaningful for the conversation, and asks himself if they might open space for the not-yet-said.

Step 4. If the introduction of the therapist's personal experiences might open space for the not-yet-said, the therapist searches for a constructive and respectful way in which his personal experience can be introduced into the outer conversation. If he doesn't find a constructive and respectful way to introduce his experience, it might be useful to consult a colleague or a supervisor.

If the therapist follows these four steps in his inner conversation, he can bring his self into the outer conversation in a careful and disciplined way that will open space in the therapeutic conversation for the not-yet-said. The therapist has to keep in mind, however, that the introduction of aspects of his self in the therapeutic conversation can be very challenging or provocative for the family, because it often entails the introduction of something new and unexpected into the conversation. That is why I want to stress the importance of finding a *constructive* way to introduce aspects of the self into the therapeutic conversation. This means remaining respectful toward the integrity and the uniqueness of the family and, as Andersen (1987) stated, "to talk about not too unusual issues in a not too unusual manner" (p. 417). Challenging should always be accompanied by a containing, supportive attitude on the part of the therapist. It should be clear to the family that the therapist is standing by the system (Andolfi et al., 1989).

The therapist should always be respectful of client responses and concerns, especially after he has introduced aspects of his self into the conversation. The therapist should be extra respectful of so-called *defensive* responses of clients. Personally, I don't see client's responses as defensive, but merely as *protective.* This is an important distinction. The term "being defensive" has a strong negative connotation, and implies that people shouldn't be defensive. The term "being protective," however, refers to the fact that people have a right to be cautious and to take good care of themselves and others. It implies that we all have our vulnerable parts, which demand concern and respect, and that's why I think it is best to accept the client's protective responses. I often encourage clients to be cautious and to protect themselves in therapy. I tell them not to go too fast and not to talk too soon about their most vulnerable aspects: "I think it is better for you to first consider if the context is safe, before you trust me with things that may make you feel vulnerable." This can of course be used as a strategic statement that works as a therapeutic paradox. For me, however, it is an ethical stance. People have a right to protect themselves, and to be cautious in situations that are strange, stressful, and potentially hurtful for them—especially people who come to therapy, because they often have already been seriously hurt in the course of their lives.

In his inner conversation, the therapist should consider not only the vulnerability of the clients but also his own. Indeed, thetherapist can also be hurt in the therapeutic conversation, especially when he uses his self, because he exposes himself as a person, and he makes himself available for comments, critique, or evaluation. The feedback of clients is often

instructive for the therapist and useful for the therapeutic process, but it can also be hurtful. This is another reason why the therapist should reflect carefully on which elements of his self he should use to promote a healing conversation.

Therapeutic Impasse

When all goes well, there is room in the therapeutic conversation for freedom and flexibility (Fine & Turner, 1991). When the therapeutic culture (Rober, 1998) is safe for the clients and the therapist, the therapist feels free to talk about everything he considers relevant for the conversation. He is not shy about asking questions he thinks are important, and he feels comfortable enough to introduce those aspects of his self that seem relevant in the session. There are no taboos; the therapist can choose from many different positions the one that, in his view, is most likely to open space for the not-yet-said (empathic listening, asking questions, advising, supporting, . . .). This may however change during the course of the therapy. Sometimes an impasse develops in the therapeutic conversation (Whitaker, 1982). In an impasse, there is no room for the not-yet-said, and the conversation becomes very poor, unanimated, and repetitive: there is no variation, freedom, or flexibility (Fine & Turner, 1991). The impasse also manifests itself in the therapist's inner conversation. The therapist feels as if he is stuck or empty or impotent. He has no ideas, or he doesn't feel helpful, or he finds himself stuck in a therapeutic role that has already proved to be unhelpful.

It is not easy to define exactly what a therapeutic impasse is. In an article about a therapeutic impasse Whitaker (1982) gives an experiential description:

> In general, the impasse consists of a deterioration in the relationship. This is characterized by emotional withdrawal in its various forms, such as intellectual discussion, emphasis on symptomatology, interest in real life and its problems, or periods of futile silence. This superficiality results in frustration and irritability. [p. 39]

Whitaker (1982) stresses the importance of the therapeutic relationship that deteriorates, the emotional withdrawal, and the feelings of frustration of therapists and clients. Haber (1990) gives a more systemic account of a therapeutic impasse when he states: "If this therapeutic impasse persists over time, . . . each of the members of the therapeutic system becomes more rigidly defined in relation to one another. . . . The impasse . . . is maintained by a set of rules that avoids a direct confrontation of the personal/interpersonal contradictions to resolving the crisis" (p. 377). Haber points to the rigidity of the therapeutic system and to the avoidance of direct confrontation. Anderson (1997) speaks of breakdown instead of impasse. She points also to the part the therapist plays in the impasse when she punctuates breakdowns as a therapist's failure to be open for the multiple realities in a given situation, and his failure to work within these realities "in a manner that opens the flow of communication rather than narrows it, and in a manner that maximizes the opportunity for ideas to be fluid rather than static" (p. 125). Considering these descriptions, we can describe therapeutic impasse as a rigid and static therapeutic conversation in which the therapist and the clients feel stuck. There is a paralysis of the circle of meaning in the sense that no space is opened for the not-yet-said. Furthermore, the therapeutic culture is narrow andunsafe, which results in emotional withdrawal and avoidance of direct confrontation in the therapeutic conversation.

Focusing on the therapist's inner conversation, we can situate the therapeutic impasse in the stage of inspiration and in the stage of courage.

1. *In the stage of inspiration,* a therapeutic impasse consists of the therapist's lack of inspiration. His thoughts are repetitive and poor. He keeps having the same thoughts and ideas over and over again (a mono-perspective). His inner conversation is characterized, on the one hand, by a repetitive preoccupation with certain aspects of the self (observations, images, ideas, . . .) and, on the other hand, by a numbness for other aspects of the self. He may, for instance, fail to see the rigidity of his inner conversation. As Haber (1990) and Anderson (1997) have observed, in most cases the therapist focuses on the defensiveness of the family and underestimates his own contribution to the therapeutic impasse. For instance, the therapist might be preoccupied by the evasiveness and suspicion of the family, not realizing he himself is very self-protective, or scared, or angry. Thus, relevant aspects of the self of the therapist remain in the not-yet-said since they are inaccesible for the therapist in his inner conversation.

2. *In the stage of courage,* the therapeutic impasse doesn't present itself as a lack of inspiration but rather as a lack of courage. The therapist knows what he should do to be helpful, but he lacks the courage to do it. He doesn't feel free to do what he thinks he should do. For instance, the therapist might have the inspiration that he could open space in the conversation to talk about the anger in the family if he would only go public with his reflections. He hesitates and doesn't dare to take the risk, because he is afraid of the possible reaction of the father, who seems very sensitive on this subject, which, of course, leads to a frustrating impasse for the therapist and the family.{tx}

Whitaker (1982) suggests as a solution for the therapeutic impasse that the therapist consults a colleague or talks about the impasse with his clients. More generally, we can say that the therapist has to take some distance and he has to reflect on his own position in the therapeutic conversation and on his own experiential process (Fine & Turner, 1991). In this process of *reflection* (Andersen, 1987, 1991), the therapist steps back from the therapeutic work sufficiently so as to develop a

more acute awareness of his observations, his ideas, his feelings, and so on, and, hence, attains a position of increased choice, flexibility, and freedom (Fine & Turner, 1991).

This process of reflection can take many different forms: "intervision" (a discussion between colleagues), supervision, inviting observers or consultants, and so on. It is essentially a process in which, preferably with the help of an outsider (colleague, supervisor, . . .), the therapist searches for the aspects of his self (his observations, his imagination, and so on) that have not been used in the conversation, or, in other words, to the things that could not be said because they might be too painful, embarrassing, unbelievable, or strange, for the therapeutic system. In this process of reflection, the inner conversation becomes partly external. The therapist uses the outsider to externalize his inner process. They reflect on his contribution to the therapeutic impasse.

In the case of the Dillen family, which will be discussed in the next and final part of this article, this process of reflection took place in a conversation with a colleague. In that conversation it became evident how angry the therapist was. Not only had that anger not been talked about in the therapeutic conversation, it even had been inaccesible for the therapist inhis inner conversation. The therapist and his colleague then reflected on ways to introduce the anger in a constructive way in the next session.

The Dillen Family

I saw a family with a rebelious teenager for a first interview. Mother cried before she had uttered one word. She was at her wit's end. She couldn't take it anymore. Father didn't say very much. He looked like a man of rules and principles. He was dressed very formally and he looked grave. The conversation started with mother complaining about her son:

"He does whatever he wants and he doesn't have any respect for us. He lies in his bed all day, he doesn't obey any rules and he refuses to go to school." Mother wept silently.

I asked father when the problem had started. Father returned the question: "Started? What do you mean by 'started'?" Although I felt father was insecure and irritated, I tried to make him tell me his story about the problem. Again he returned my question. I reflected for a moment and then realized that I didn't know what he expected from therapy yet. Why hadn't I asked about his expectations first as I usually do? Could it be that I was hasty in focusing on the problem under pressure of mother's tears? Or was there something else?

Then I asked father why he wanted therapy, what he expected from therapy? Father said, still irritated, that he only wanted someone to talk some sense into his son. I asked father why he needed a therapist for that. He answered: "I don't need a therapist. I only want someone to talk some sense into my son. So he starts to obey some rules again. So that he can see reason again. So that he knows wrong from right again. Repeatedly I told him wrong from right, but he just doesn't listen to me." I sensed that fathers self-esteem was very low, and I asked him why he thought his son might listen to me if he didn't even listen to his father. "You have done studies in psychology, haven't you?" he answered shortly.

I felt my irritation rising, but I didn't know how I could introduce what I was feeling in a constructive way. I didn't want to endanger the new and still vulnerable therapeutic relationship by talking about it so soon in the conversation. After all, we had only just met a few minutes ago. I wondered how it was possible for me to be irritated so much after just a few minutes of being in the room with this family. Then I realized that the parents probably felt impotent, that they felt as if they didn't have any influence on their son whatsoever. Father only seemed concerned with showing how abnormal his son was and with repeating the importance of rules and regulations. Perhaps he doesn't feel understood by me, and he is probably right, I thought. I tried to talk some more with the father about the family, but my rapport with father didn't improve. I felt stuck. At the end of the session we weren't any closer to a workable therapeutic relationship. Politely, we made an appointment for the following week.

After the interview I felt bad; I was angry with father because he was so rigid and I was angry with myself because I wasn't flexible enough to do something constructive in the session. I felt that I was worthless as a therapist. A few days later I asked a colleague to help me to understand what had gone wrong in the session. I needed distance and reflection. In the conversation with my colleague, I intended to first give the bare, objective facts of the session, but I soon noticed that I was ventilating my anger. I said that the father saw only black and white, normal and abnormal, life and death. "He lives in a world where freedom doesn't exist, and if there is no freedom, how can there be room for the beautiful things in life?" Irattled on: "In fact, that man doesn't live anymore," I claimed. "He is dead, only he doesn't realize it yet." My colleague didn't interupt my angry outburst. He listened to my accusations and my frustration. All of a sudden, I stopped talking, and I was astonished about my own raging anger. As we talked some more about the family and about my feelings, I realized that the father must have felt completely misunderstood. He probably had also felt my irritation, which must have made him feel even more threatened. I realized that I must do something with my anger in the following session.

In the second session with the Dillen family I started by asking if anyone wanted to comment on the first session. Mother said she didn't want to comment. I looked at father, who was staring at his shoes, silent, pensive. Then father said, "I don't know, it seems like I have forgotten everything we talked about last week." I looked at him and I nodded. I thought I

understood why he had forgotten everything. That conversation must have been a terrible experience for him.

Then I said I wanted to comment on the first session. I told them that I had felt very bad after the session. I said that I felt there had been an escalation of irritation between father and me. I said I had been irritated and that I realized that meant that I hadn't really understood him. I looked at father and asked him if indeed he had felt misunderstood. Father said that he had felt provoked by me. "Provoked?" I asked, amazed. "Yes," father said. "You wanted to challenge me, to see how I would react." I was astonished. I hadn't thought about that at all. I apologized and explained that it hadn't been my intention to provoke him: "I just wanted to talk with you about your son, and about what I could do to help you with your problems," I explained.

The atmosphere of the conversation was completely different from that of the previous session. Father and I were talking freely and in an uninhibited way. I felt relieved of a heavy burden. Although father was still very rigid and strict, I began to feel sympathy for him. At that moment father said, "Of course, also my diabetes is to blame."

I could sense a shock going through the family. Mother looked at father and the son looked at mother, bewildered, as if they couldn't believe what they had just heard. Then there was a silence. I looked around at the family members and I asked myself what was going on. Was father's diabetes a secret in the family that was now revealed for the first time? I doubted that. Was it something that could not be talked about because it was too painful? I remembered my conversation with my colleague and my image of father being dead and not yet knowing it.

"Can you tell me some more about your diabetes?" I asked father. I tried to phrase my question as neutral as possible, and I wanted to sound as gentle as I could, because I felt this was a very sensitive subject. Father told me that he had suffered from diabetes for some years now: "It's a very unstable kind of diabetes," he said, "and it has changed my life considerably." "What do you mean?" I asked. "In fact I don't live anymore," father said. "In fact I am dead since I got this disease. I try to hold onto life as hard as I can because I don't want to die. But I have to admit that I stopped living. I don't enjoy life anymore."

Father then started to recount how he couldn't bear emotions anymore. He tried to keep all emotions at a safe distance:

> When I start to feel things, I close myself like an oyster, and I try to think of something else. For instance, the other day I went to the movies with my wife. It was a very romantic movie and I couldn't bear it, and I started to count the seats in the movie theater, and Ibegan to calculate what the profit of the company that owns the theater would be when the house was sold out. I don't want to feel any emotions anymore. It hurts too much

I saw tears in father's eyes. Mother and son too were very moved. They sat in silence, reverently. Then mother spoke, in a low voice: "It's true, the disease changed him completely. He became very strict and rigid. Everything had to be planned and everything had to go by the book. He became also very closed and he never wanted to talk, especially not about diabetes. This is the first time he's spoken about it." "It is also the last time," father said rapidly. "I agree to talk about it today, so that you can understand me and so that you can understand why I can't handle my son. But after today, I don't want to talk about it any more. It is too emotional for me."

We talked some more about his disease and about what it meant for his life and for his family. At the end of the session I said I was very glad we had talked about it. "I think I understand you now," I said. I added that, if father wished, we could talk about his disease some more in the future. Father said he didn't want that. I felt again his strictness, but this time it didn't irritate me. I set another appointment for the family, and we said goodbye.

Discussion

This case illustrates that, in the therapeutic impasse, the therapist in his inner conversation is preoccupied by one observation (the rigidity of father), while at the same time he is unaware of other aspects of his self (especially his anger). This case can also be read as an illustration of Elkaïm's idea of the function of the feelings of the therapist for the therapeutic system (Elkaïm, 1989, 1997). The therapist's irritation helps to maintain the distance and insecurity in the therapeutic system in such a way that father feels justified in not taking the risk of trusting someone with his most vulnerable feelings. Furthermore, this case illustrates that it is important for the therapist to reflect on his own position in the therapeutic conversation, and to keep in touch with his own self. In the second session, when the therapist—after his reflecting conversation with his colleague—introduced the aspect of his self he had been numb to in the previous session, space was opened for the not-yet-said, that is, the story about father's disease and the influence it had had on everybody in the family. Everyone suffered from the disease, but they couldn't talk about it. The self-disclosure by the therapist of his discomfort after the previous session made it possible for the father to talk about his disease and about his struggle. The therapist then could see father's rigidity as a part of that struggle. The new story that developed in the conversation was not the story of a rigid and difficult man who tried to control everything around him, including his wife and his son. Instead, it was the story of a man who suffered from a terrible disease that threatened his very being. It was the story of a man who

tried hard to lead a good life. Being able to tell the story of his existential struggle restored to the father his dignity as a human being.

CONCLUSION

The not-yet-said is infinite. There are always other sides to the story; there are always words that haven't been spoken. As therapists, we are always *on the way to understanding* our clients (Anderson & Goolishian, 1992), never reaching our final destination of complete understanding. In this article, I have described one route to understanding our clients, namely, through taking seriously what the client evokes in our inner conversation. I haveproposed that the therapist should be open, not only to his observations, but also to the personal experiences these observations evoke in his inner conversation because these are rich resources that can help open space for the not-yet-said in the therapeutic conversation, or give access to subjugated knowledge. These aspects of the inner conversation, however, should not be introduced into the outer conversation without some reflection on the part of the therapist. In his inner conversation, the therapist has to search for constructive and respectful ways to use aspects of his experiences in the conversation with the family. In this context, it is clear that the concept of not-knowing doesn't refer to the emptiness of the therapist's mind as a neutral, blank screen. To the contrary, it refers to the therapist's being in continuous contact with himself in his inner conversation, in order to use his experiences in a collaborative and respectful way in "a process of forming, saying, expanding the unsaid and yet-to-be-said—the development, through dialogue, of new meanings, themes, narratives, and histories—from which new self descriptions may arise" (Anderson, 1997, p. 118).

Furthermore, in this article I described therapeutic impasse as a paralysis of the circle of meaning of the outer conversation. I maintained that the impasse also manifests itself in the inner conversation, where it is experienced as a lack of inspiration or a lack of courage. I have proposed a process of reflection as a way out of the impasse, and I hope I made it clear that, although therapeutic impasse is often experienced by therapists as an ordeal, it can also be welcomed as a great opportunity. Often, in retrospect, a therapeutic impasse proves to be a key moment in the therapy. The succesful dissolution of the impasse is usually experienced by therapists and clients as a giant leap forward, because space is suddenly created to say what could not be said until then.

REFERENCES

1. Andersen, T., (1987) The reflecting team: Dialogue and meta-dialogue in clinical work. *Family Process, 26,* 415-428.
2. Andersen, T., (1991) *The reflecting team: Dialogues and dialogues about the dialogues.* New York: W.W. Norton.
3. Andersen, T., (1992) Reflections on reflecting with families (pp. 54-68). In S. McNamee & K.J. Gergen (eds.), *Therapy as social construction.* London: Sage Publications.
4. Anderson, H., (1997) *Conversation, language and possibilities: A postmodern approach to therapy.* New York: Basic Books.
5. Anderson, H. and Goolishian, H. A., (1988) Human systems as linguistic systems: Preliminary and evolving ideas about the implications for clinical theory. *Family Process, 27,* 371-393.
6. Anderson, H. and Goolishian, H. A., (1990a) Beyond cybernetics: Comments on Atkinson and Heath's "Further thoughts on second-order family therapy." *Family Process, 29,* 157-163.
7. Anderson, H. and Goolishian, H. A., (1990b) Strategy and intervention versus nonintervention: A matter of theory?, *Journal of Marital and Family Therapy, 18,* 5-15.
8. Anderson, H. and Goolishian, H., (1992) The client is the expert: A not knowing approach to therapy (pp. 25-39). In S. McNamee & K.J. Gergen (eds.), *Therapy as social construction.* London: Sage Publications.
9. Andolfi, M. and Angelo, C., (1988) Toward constructing the therapeutic system. *Journal of Marital and Family Therapy, 14,* 237-247.
10. Andolfi, M., Angelo, C. and De Nichilo, M., (1989) *The myth of Atlas: Families & the therapeutic story.* New York: Brunner/Mazel.
11. Aponte, H. J., (1992) Training the person of the therapist in structural family therapy. *Journal of Marital and Family Therapy, 18,* 269-281.
12. Baldwin, M. and Satir, V. (Eds.), (1987) *The use of self in therapy.* New York: Haworth Press.
13. Cooklin, A., (1994) Response to Haber. *Journal Of Family Therapy, 16,* 285-291..
14. Dell, P. F., (1989) Violence and the systemic view: The problem of power. *Family Process, 28,* 1-14.
15. Elkaïm, M., (1989) *Si tu m'aimes, ne m'aime pas* [*If You Love Me, Don't Love Me*]. Paris: Seuil.
16. Elkaïm, M., (1997) *If you love me, don't love me: Undoing reciprocal double binds and other methods of change in couple and family therapy.* Northvale NJ: Jason Aronson.

17. Epston, D. and White, M., (1992) *Experience, contradiction, narrative & imagination: Selected papers of David Epston & Michael White, 1898-1990.* Adelaide, South Australia: Dulwich Centre Publications.
18. Erickson, G. D., (1988) Against the grain: Decentering family therapy. *Journal Of Marital And Family Therapy, 14,* 225-236.
19. Fine, M. and Turner, J., (1991) Tyranny and freedom: Looking at ideas in the practice of family therapy. *Family Process, 30,* 307-320.
20. Gadamer, H. G., (1988) *Truth and method.* New York: Crossroad.
21. Gergen, K. J. and Kaye, J., (1992) Beyond narrative in the negotiation of therapeutic meaning (pp. 166-185). In S. McNamee & K.J. Gergen (eds.), *Therapy as social construction.* London: Sage Publications.
22. Goldner, V., (1985) Feminism and family therapy. *Family Process, 24,* 31-47.
23. Goolishian, H. A. and Winderman, L., (1988) Constructivism, autopoiesis and problem determined systems. *The Irish Journal of Psychology, 9,* 130-143.
24. Haber, R., (1990) From handicap to handy capable: Training systemic therapists in use of self. *Family Process, 29,* 375-384.
25. Haber, R., (1994) Respons-ability: Therapist's "I" and role. *Journal Of Family Therapy, 16,* 269-284.
26. Hildebrand, J., (1998) *Bridging the gap: A training module in personal and professional development.* London: Karnac.
27. Hoffman, L., (1991) A reflexive stance for family therapy. *Journal of Strategic and Systemic Therapy, 10(3/4),* 4-17.
28. Imber-Black, E., (1986) Maybe "lineal causality" needs another defense lawyer: A feminist response to Dell. *Family Process, 25,* 523-525.
29. Keeney, B. P., (1983) *Aesthetics of change.* New York: Guilford Press.
30. Lakoff, G. and Johnson, M., (1980) *Metaphors to live by.* Chicago: University of Chicago Press.
31. Larner, G., (1996) Narrative child family therapy. *Family Process, 35,* 423-440.
32. Lowe, R., (1990) Re-imagining family therapy: Choosing the metaphors we live by. *Australian & New Zealand Journal of Family Therapy, 11,* 1-9.
33. Paré, D. A., (1995) Of families and other cultures: The shifting paradigm of family therapy. *Family Process, 34,* 1-19.
34. Parry, A., (1991) A universe of stories. *Family Process, 30,* 37-54.
35. Penn, P. and Frankfurt, M., (1994) Creating a participant text: Writing, multiple voices, narrative multiplicity. *Family Process, 33,* 217-231.
36. Postman, N., (1989) *Conscientious objections: Stirring up trouble about language, technology and education.* London: Heineman.
37. Rober, P., (1998) Reflections on ways to create a safe therapeutic culture for children in family therapy. *Family Process, 37,* 201-213.
38. Real, T., (1990) The therapeutic use of self in constructionist/systemic therapy. *Family Process, 29,* 255-272.
39. Selvini-Palazzoli, M., Boscolo, L., Cecchin, G. and Prata, G., (1980) Hypothesizing-circularity-neutrality: Three guidelines for the conductor of the session. *Family Process, 19,* 3-12.
40. Scharff, D. and Scharff, J., (1991) *Object relations family therapy.* Northvale NJ: Jason Aronson.
41. Scharff, J., (1992) *Projective and introjective identification and the use of the therapist's self.* Northvale NJ: Jason Aronson.
42. Slipp, S., (1991) *Object relations: A dynamic bridge between individual and family treatment.*Northvale NJ: Jason Aronson.
43. Tilmans-Ostyn, E., (1990) Développement de l'utilisation du soi de thérapeute: Une phase de formation en thérapie familiale [Development of the use of the self of the therapist: A phase in family therapy training]. *Thérapie Familiale (Genève), 11,* 127-138.
44. Tilmans-Ostyn, E. and Rober, P., (in press) Een opleidingsmodel voor het therapeutisch gebruik van het zelf voor gezinstherapeuten [A model for the training of the use of the selffor family therapists]. *Tijdschrift voor Psychotherapie, .*
45. Tomm, K., (1993) Interviewing the internalized "other." Workshop at the 5th World Family Therapy Congress, Amsterdam, The Netherlands.
46. Whitaker, C. A., (1982) The psychotherapeutic impasse (pp. 38-44). In J.R. Neill & D.P. Kniskern (eds.), *From psyche to system: The evolving therapy of Carl Whitaker.* New York: Guilford Press.
47. White, M., (1991) Deconstruction and therapy. *Dulwich Centre Newsletter, 3,* 1-21.
48. White, M., (1995) *Re-authoring lives.* Adelaide, Australia: Dulwich Centre Publications.
49. White, M. and Epston, D., (1990) *Narrative means to therapeutic ends.* New York: W.W. Norton.

Manuscript received March 5, 1998; Revisions submitted March 5, 1998; Accepted December 22, 1998.

[1]In Anderson (1997, p. 125).

[2]For the sake of brevity, the client and the therapist are referred to by the masculine pronoun.

[3]In this article, the narrative perspective in family therapy refers not only to the narrative therapy as developed by Michael White and David Epston, but also to all family therapy approaches that are based on narrative metaphors like conversation, story, dialogue, text, and so on.

[4]Since the word "manager" is not consistent with the view that participation and collaboration are central to the therapeutic conversation (Real, 1990), I prefer the term "participant-facilitator."

[5]Different authors use different words to describe the same thing. Tom Andersen (1992) speaks of an *inner voice* or an *inner talk* or an *inner conversation;* Penn & Frankfurt (1994) use both *inner conversation* and *internal dialogue;* and Harlene Anderson (1997) speaks of an *internal dialogue.* I choose *inner conversation* because it seems to be the term most generally used in the family therapy literature.

[6]In the psychoanalytic literature there are many publications about countertransference that cover some of the same ground. This article is not the right place to review this rich tradition. However, of the many relevant psychoanalytical publications, I refer especially to the writings of object relation therapists like Slipp (1991), Scharff and Scharff (1991), and Scharff (1992) because they have tried to bridge the gap between individual psychodynamic treatment and family therapy, thereby underscoring the importance of countertransference.

[7]In retrospect, I recognized that the image of the wounded wolf came from Cormac McCarthy's novel *The Crossing,* which I had read a few years ago, and which had moved me very much.