shake UP

Moving Beyond Therapeutic Impasses by De-Constructing Rigidified Professional Roles

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C & E Limited
Publisher

Title: Shake-UP: Moving Beyond the Therapeutic Impasse by De-Constructing Rigidified Professional Roles

Printed in the United States of America
First Published: 2012 by C & E LTD
2 3 4 5 6 7 8 9 10
ISBN Number: 978-0-615-60893-8
Library of Congress Control Number: 2012905873
Nur: 770 (Psychology)
Writing, Publishing and Distribution of the book made possible by:
ISSOOH, Institute for System Approach; Training and Research.
Publisher Information:
C & E Ltd.
6400 Monroe Street, St. E
Sylvania, Ohio 43560
Phone (USA) 1-800-532-5464
Copy Editors: Kenneth L. Miller
Stacey Lynn Osborn
Cover Design and Illustrations: Jan van Gastel
Graphic Designer: Susan Panning
Text Designer: Dawn Freeman
Web Designer: Sandra Lee Emerson
Printer: Superior Impressions
Webpage: www.shake-UP.us

Dedication

To Marijke and John, our spouses and friends, the influential parts of our own "living culture", who are traveling the journey of life with us and helping to create the family that enriches our life and recreates the personal and professional roles we activate each day.

Preface

Therapeutic impasses are seduced processes that occur within a therapeutic session between clients and the therapist. When an impasse develops, all members of the therapeutic system become stuck and only minimal progress is made by the clients; often therapy ends prematurely. The purpose of this book is to assist both novice and seasoned therapists to identify and reflect upon the types of professional therapeutic roles that they assume in their practice, some of which may lead to impasses. Through reflection and self-awareness of their developmental family, social, and work settings, therapists are first encouraged to deconstruct their professional framework to see where they might enhance their work patterns. To move out of an impasse or, as the text suggests, the assumption of a seduced role, therapists must reflect upon the type of professional role being employed with clients and begin to think about other professional therapeutic roles that could be activated to deconstruct the impasse. By engaging in this process, therapists can move clients to a higher level of restructuring that will promote change. Each chapter guides the reader into a higher level of understanding of his own therapeutic professional development, preferred professional therapeutic roles, and to quickly identify those professional therapeutic roles to which he can shift when an impasse develops.

The twenty-six chapters and forward written by an internationally renowned expert in the field, Russell Haber of the USA, are provocative. Readers will benefit through encouragement to reflect on their personal growth, their own "living culture" and professional development to re-think their positions within a therapeutic session. The reflection section of each chapter encourages deep reflection, challenges current professional therapeutic positions, and thereby promotes long-term professional development. Finally, as the book is written from the viewpoint of both a psychologist, psychiatrist, and edited by a licensed professional clinical counselor who is certified as a medical psychotherapist the text is applicable to a broad range of mental health professionals (e.g., psychiatrists, psychologists, counselors, medical psychotherapists and clinical supervisors) who provide psychotherapy services from an interactive viewpoint and is accessible for immediate use.

Contents

Acknowledgements

A very special thank-you is extended to those that have contributed to our "living culture" and professional growth throughout the years which helped to shape the making of this self-help book:

Maurizio Andolfi, Rome, Italy
Vincenzo DiNicola, Montreal, Canada
Russell Haber, Columbia South Carolina
Jorma Phia, Turku, Finland
Rick Pluut, Castricum, The Netherlands
Frederik Snyders, South Africa
Yme Speerstra, The Netherlands

Special Acknowledgement to our Editors and Illustrator:

Kenneth L. Miller's edits were invaluable. His experiences as a clinical counselor, supervisor, university instructor and ability to expand on information with such precise clarity added breadth and depth.

Stacey Lynn Osborn, whose creativity, fun, imagination, and editing style gave a significant shape to this book.

Jan van Gastel, whose illustrations and creativity brought the professional therapeutic roles to life.

In addition the following people provided significant contributions to the formation of this book:

Kara McCourt, Bowling Green State University Student
Melanie East, Graduate Assistant, Youngstown State University
Susan Panning, Graphic Designer
Susan Miller, Educational Consultant

Finally, special salutations go to our dear friend, *Frederik (Ricky) Snyders,* whose provocative questions, clarifications, therapeutic insight/experience, interest, and curiosity led to the grounding of this book.

Making of a Therapist

Part of life is hardship; it's a journey through a maze
No one makes it out alive, but we learn from every day.
Our family truly impacts the roles we choose in life
This may bring joy, happiness and even cause some strife.
No one family follows a certain set equation
Families differ with closeness and separation.
One may try to forget where they came from and who they are within
But the past will always follow them; from history one cannot run.
The people we call family may have their ups and downs,
They may fight and argue and bicker with us, or even have emotional breakdowns.
But the most important aspect of family
Is it sets up who we are and molds the roles we engage
Throughout life each and every day
So although one may separate or even break all ties
A family cannot be undone
As one's living culture and uniqueness thrives from within.

From life's experiences and interactions
A professional role is enacted
To analyze a family's presenting symptoms.
All aspects are considered and assessed from every angle.
The family unit is respected as complexity is untangled
Seeking answers and the reasons for the distress that is revealed
Is the process of helping the family to heal
The family history holds the key to help unlock uncovered solutions
and allows the family freedom to discover their own resolutions.

Kara McCourt, 2012

Foreword

It is a pleasure to write a foreword to this highly creative description of how to both productively and meaningfully engage in therapeutic relationships. *Shake-UP* vividly demonstrates that while impasses are unavoidable, the therapist holds the keys to circumvent his or her impasse. The book is filled with dozens of case scenarios that artfully illustrate resourceful ways to approach individual, couple, or family therapy. Beware that this book is not for therapists to read quickly or indifferently. The authors request the reader to reflect upon the precursors (family of origin, social network, school, and work influences) that shape reflexive approaches in stressful therapy sessions. This book does not provide the "right" method to practice psychotherapy, but offers a framework that can help therapists become more conscious, purposeful, and differentiated presences in the therapeutic system.

How does one's style and bias as a therapist help clients and how does it impede progress and the process of systemic psychotherapy? My personal answer to this question emerged as I pondered the effectiveness of therapeutic work with a couple nearing termination. One day, my wife, Dr. Karen Cooper-Haber and I conducted a planned termination session of a successful marital recovery from an affair. The wife asked us if we knew what we did that she found to be most useful in the entire marital therapy that spanned more than a year. I remembered our processing her husband's anger at the revelation of the affair, her emotional grief about her early losses, and countless other empty chair, sculpting, and metaphorical object interventions. It was like a near death experience where I saw pivotal interventions and therapeutic moments in slow motion. My brain became so crowded with possibilities that I simply said, "No, what?" Her answer rocked my world of assumptions about what works in therapy. She said, "it was the time when you two were having an argument and you said that you needed to finish the argument before you would see us. Your model gave my husband and me the permission to finish our problems before dealing with our children, going to work, or any other responsibility. You put the marriage first and this helped us to do the same." This scenario was not even in my consciousness as I contemplated the most useful moment. In hindsight, I should have guessed that it was something that was relationally focused rather than technique driven.

Shake-UP provides a rationale and methodology that supports our decision to resolve our argument before starting that session. To use Ellenwood and Brok's metaphors, my wife temporarily abandoned her professional therapeutic roles as the Angel, the Bird-watcher, and the Detective, while I gave up my professional therapeutic roles as the Clown, the Mediator, and the Savior. How nice it must have been for our clients to get a glimpse of our marital reality rather than the busy-ness of all our professional therapeutic roles. Instead, the couple was presented with our mutual "construction workers," who needed a boundary in order to regain our balance. This shift in our characteristic professional therapeutic roles for the sake of our relationship gave permission to our clients to be more intimate in their own lives.

The practice of prioritizing the effect of the therapist more than the dynamics within the client system began in 1981 when Lars Brok and I participated in a Family Therapy Practicum with our mentor/teacher, Maurizio Andolfi. This practicum began a lifetime journey that focuses on the ethical and effective use of self to solicit and empower client resources within a transgenerational and multicultural context. Maurizio Andolfi has developed therapeutic, supervisory, and training methodologies that foster the ability of the therapist to consider his or her contribution to the impasse in the therapeutic relationship, rather than blaming the family for their inability to succeed in therapy. Ellenwood and Brok have aptly continued this tradition by presenting a model that develops the therapist's capacity to vary his/her approach based unique client needs. After all is said and done, the best asset that we possess is our ability to creatively engage in the therapeutic system. This book promotes a language and a myriad of techniques that facilitate the therapist's use of self.

Abundant empirical justification of more than fifty years acknowledge that common factors, most notably the quality of the therapeutic relationship, is more responsible for successful therapeutic outcomes than the use of any specific theory or technique. Many outcome-oriented therapists see improvement of the working alliance as the means of achieving better outcomes. From beginning to end *Shake-UP* effectively attends to the complexities of the working alliance. The clear intent of this book is to move therapeutic relationships from impasse and redundancy towards freedom and flexibility. The authors approach impasse as an opportunity rather than a dreaded event. Therapeutic impasse can be seen as a redundant dance where each one's steps seem mutually and systematically choreographed by the other ("I did this because you did that."). This book gives refreshing "dance instructions" introducing new steps in lieu of overused and clumsy footwork.

I learned long ago, while doing my professional handicap work with Maurizio Andolfi, that I needed to sometimes create therapeutic distance through humor or (archaeological) research to offset the Savior part in me. In a role-play with a suicidal wife and a comically, irrelevant husband (played by one of the authors of this book, Lars Brok), I tried to save the wife from her personal misery and dysfunctional marriage. I became burdened with the responsibility of saving the wife and consequently felt "seriously" stuck. Maurizio Andolfi helped me to find ways to create more distance through my sense of humor, working with their polarities, and finding language to avoid feeling burdened by their pain. I was able to improvise rather than resort to old, familiar patterns. Thus, I became more "response-able" (a true means of being responsible). In much the same way, Ellenwood and Brok's book provides language to describe my move from the Savior to the Clown, the Detective, and the Archaeologist.

This book is definitely an antidote to therapist burnout. The authors' creative, spirited, and inspirational approach to helping their clients is present in almost every page of their book. I felt moved by the courage and imagination illustrated in their many clinical anecdotes. Reading their book has reminded me that even after 30+ years as a family therapist, I still overuse approaches that limit my creativity and effectiveness. I want to thank Lars and Audrey for giving me more language and metaphors to find latent resources. You have reminded me to embrace the awareness that changing my position in the system can foster a chain reaction.

One caveat that I would give to the reader: consider reading the last (Reflections of the Authors) chapter first. This chapter will introduce you to Audrey Ellenwood and Lars Brok and their respective learning and work systems. You will also meet their common denominator, Maurizio Andolfi, and the international network that has been part of this multi-cultural exploration about how to most effectively influence distressed families. In this chapter, both authors introduce their personal characteristic positions that they assume in the therapeutic system. Finally, you will read three examples of brilliant therapy in chapter 25. This chapter will no doubt provide a strong impetus to read, study, and, reflect and *Shake-UP* your therapy.

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Introduction

When client meets therapist, a vortex of problem-saturated interactional patterns engulf the therapeutic system, and the psychotherapist is immediately constrained by the roles and functions the client delegates to him, as well as the limitations imposed by his own restricted role repertoire, epistemology, and phylogenetic programming. "Shake-UP" is a timely contribution to the mental health field, in that the authors provide a comprehensive model of how to enhance therapist maneuverability, maintain essential orthogonality, and free the therapist from the problem-saturated and very seductive client or family vortex.

The volume will be useful to novice and experienced therapists in that it connects therapeutic impasse, therapist and client variables, the therapist's role as choreographer of the therapeutic encounter, and the therapist's use of self. Techniques and models may be viewed as sets of behaviors exhibited by therapists in interventive contexts, and this book is rich in describing a wide array of alternative roles and techniques available to therapists in the face of systemic impasse. Beyond the phenomenon of impasse and stuckness, therapists are alerted to the programming emanating from their living ecologies, families of origin, training, experience and ways of thinking. Therapists are advised to think about their thinking and doing in creative ways, and the illustrative case examples add to the richness of this volume.

Drs. Ellenwood and Brok set an example by describing their own journeys of learning, as well as the provocations that brought them to applying solid interactional and strategic creativity in their shake-UP of entropic systems. This book is a breath of fresh air in a family therapy and mental health field in impasse.

Frederik J A Snyders
Emeritus Professor and Research Fellow
University of South Africa
Pretoria

Part 1

Some Theoretical Background

Chapter 1

Impasses in the Therapeutic Session

Cathy was about 40 years of age and appeared angry when she entered the therapy room. She looked around and then sat with her arms across her chest, not making eye contact. She quickly spoke before the therapist even had a chance to say, "Hello".

"I'm not really sure I should want to be here. Where is your computer?" she said.

"Can you share with me your hesitation about coming to therapy?" the therapist asked.

"I have only had one other experience with a psychologist, and I was so angry I never wanted to see another psychologist again. But you seem different to me; you don't have a computer. "

"Well, yes", the therapist replied. "I do have a computer in my billing area, but I am confused as to why the computer being present in the session is a concern. Can you share about the computer?"

"It was a horrible experience," she began and continued to speak non-stop for several minutes. My client was a police officer who had injured her back while struggling with a felon. She could no longer work and reported being in constant pain. Her marriage was reportedly suffering because her husband, also a police officer, became a constant reminder of what she used to be.

She took a breath, and then the therapist interjected, "Okay so share with me, was it hard for you to walk into the first therapist's office?"

"Oh no, that was easy," she replied.

"Okay, so once in the office, what happened?" the therapist asked.

She continued by sharing that the therapist gave her a quick hello and then sat behind a large desk. But as soon as she started talking, the therapist turned sideways, made no eye contact, and started typing on his computer. The therapist interjected from time to time, "What else can you tell me?" as if she was not even in the room. "All I could focus on was the, CLICK, CLICK, CLICK of the keyboard. The session ended and he did not even get up from his chair to say good-bye. He set another appointment on his computer for one week, and I left feeling angry, unappreciated, unimportant, and very mistrusting."

On the recommendation of friends, I kept the second appointment, and the therapist repeated his actions. I asked to see the notes and wanted to know what he was planning to do with them; I demanded that he print them out. To my dismay,

the notes were full of grammar and punctuation errors, misinterpretation, and inaccurate recordings of what I had shared.

"After reading the notes," she continued, I got up, left the room, and pledged never to go back to a psychologist again."

"But your are here?" I added, pausing for her response.

Your behavior as a therapist can influence a client's reaction to therapy and can be the core from which an impasse develops between you and your client. In the above case, the professional therapeutic style of the *Secretary* was unconsciously enacted in the session, resulting in an impasse between the client and therapist. The computer, the desk, and sideways stance of the therapist as notes were being typed impeded a connection with the client. Dutifully, the therapist said little but recorded a lot and was seemingly unaware of the client's discomfort. His aloof position was reinforced by the presence of the desk and computer. As the Secretary, the therapist, offered little advice and appeared to engage in note-taking rather than observing the client's interactional nonverbal messages. As a result, the therapist failed to attend to the client's nonverbal cues of frustration and anger. The primary message perceived by the client was, "what I share is worth recording but my actions have no value." In the above situation, the therapist appeared to be unaware of how his professional therapeutic style was being perceived by the client. As a result, a therapeutic impasse developed, and the client prematurely terminated therapy and her opinion of psychologists became severely tainted.

At some point in your professional career, you may have found yourself involved in a therapeutic situation that is so difficult that no progress can be made, regardless of your skill level, years of experience, or therapeutic techniques utilized. Therapeutic impasses are unconscious seduced processes that occur within a therapeutic session between the clients and the therapist. When an impasse develops, all members of the therapeutic system become stuck and clients make only minimal progress. The end result is that either the client or the therapist often terminates therapy prematurely. Treatment impasses have been viewed from many different perspectives over the years and many therapists have tried to understand why they occur. Various theories and techniques have been developed to counteract the impasse process, however, only a few of these processes have proved effective in altering an impasse state over time.

Therapeutic impasses have been addressed by many master level therapists (Andolfi, 1979; Cullari, 1996; Elkind, 1992; Gedo & Gehrie, 1993; Greenberg & Johnson, 1988; Pope, Sonne & Holroyd, 1993; Strean, 1985; 1990; 1991; 1999; 2000; 2001). The feeling of "stuckness" has often been attributed by many as inexperience

of or the application of poor therapeutic techniques by the therapist (Vanderheyden, 2005) while others have suggested the issue is related to a mismatch between therapist and client (Elkind, 1992).

Elkind presented a theoretical framework for understanding and working with therapeutic impasses. Her approach addressed the: (1) mismatches between therapist and client; (2) stalemates that result from therapist/client collusion; (3) conflicts and power struggles that are irresolvable; (4) breaches in the attachment bond; and, (5) untimely terminations. Elkind implied that an impasse developed when patients and therapists functioning as relational partners become rigid, operate outside of consciousness, and when the vulnerabilities and defenses of patient and therapists intersect in problematic ways. Elkind introduced a process that humanizes the patient and therapist through the recognition of human limitations. The moment a therapist recognizes the existence of an impasse and defines the therapeutic enterprise as stuck, stalled, or ineffective, both sides may have already become defensive and the therapeutic process, which normally helps clients, is now unsuccessful.

Gedo and Gehrie (1993) referred to impasses as stalemates that result by reducing human complexity to relatively simple schemas, through the use of inappropriate theories to make deductive inferences that miss the individual's core experiences of life.

Strean (1985; 1990; 1991; 1999; 2000; 2001) further described difficult patients, as those who stir up overwhelming counter-transference problems in the therapist. These counter-transference problems are difficult for the therapist to resolve. The impasse is then viewed as being related to the therapist's difficulties in relating to the patient and thus placing a "label" on the client's resistance (e.g., borderline, psychopathic etc.). Some patients are viewed as working very hard to defeat the therapist. Strean discussed the need for therapists to refine their technical skills in order to learn more about the patient's dynamic personality constellations.

Cullari (1996) discussed the concept of resistance and postulated that resistance was related to a broad category of complex interactive factors associated with the process of change. Resistance was viewed as a dynamic interrelation process where both the client and therapist influence each other. Change, flexibility, and treatment effectiveness happened through the application of various recommendations. Resistance was defined as being primarily related to conflicts arising from simultaneous attempts at self-preservation and self-transformation both within the client and between the client, therapist and society. Cullari presented an interactive model about change, flexibility, and treatment effectiveness through the application of various recommendations or therapeutic hints.

According to the Sivan S. Tomkin Institute (2002), a therapist will recognize an impasse when clients within a session seem to be saying the same things over and over with some understanding of the presenting concerns, but no change occurs in and between the clients. At this point within the therapeutic process, the therapist and clients both feel helpless and bored, while disappointment with each other builds.

Pope, Sonne, & Holroyd (1993) indicated that even after the most sustained exploration of a situation, the course in therapy may still remain unclear for the therapist. During such sessions, it is possible that the therapist may become stuck and fail to act. These authors further espoused that when a therapist refrains from implementing a contemplated action (e.g., blocking negative interactions among the clients), the therapist's spontaneity, creativity, intuition, and ability to help may become hindered, resulting in impeding the client's progress.

Vanderheyden (2005) suggested that "stuckness" may be more reflective of the therapeutic relationship or the isomorphic nature of the therapist, treatment approach, or client's life. Others have referred to "stuckness" in terms of the therapist's and clients' lack of self-awareness or self-reflection from the therapist viewpoint (La Torre, 2005; Lauterbach & Becker, 1996; Rober, 2011). In order to understand the impasse, these authors espoused that therapists need to take the time to reflect upon their reactions to clients, the content of therapy, and the therapist's physical responses and attitudes toward the family (La Torre, 2005; Lauterbach & Becker, 1996; Rober, 2011; Vanderheyden, 2005).

Pugh, McColgan, & Pruitt (1986) stated that an impasse relates to the therapist's ignorance about the fit of all the patterns and pattern pieces involved within and around the clients' and the therapist's fears of failure, loss of control, loss of "face" or involvement within the session. These authors indicated that the essence of the therapist's role in a therapeutic impasse is the result of ignorance and fear that develops within the therapist because of the client's typology, the confusion from too much information being presented by the clients, or the expressed tensions that arise in a session.

During sessions characterized by therapeutic impasses, most seasoned therapists automatically move into another, more effective professional therapeutic role, thus establishing change with most clients. However there are times when clients will seduce even the most experienced therapist into rigidly adhering to a particular professional therapeutic role. In turn this will lead to an impasse, resulting in lack of movement within the therapeutic process for both the client(s) and the therapist.

Throughout the book the term *seduction* is frequently used. By seduction, the authors mean that clients unconsciously lead the therapist astray from productive therapeutic processes and techniques that could be effective in helping them change.

From the authors' viewpoint, this seduction occurs when the individual, couples, or family have a special need for a member within their system to assume a specific role in their current situation. Often, such a role had been utilized by another important family member who has either left the family (e.g., college, died) or unconsciously has shifted to another role. The absence of the role within the family has been missed and relational problems are at stake. In such cases, clients unconsciously try to transfer this missing role onto the therapist, and thus the therapist becomes an "ad hoc family member."

Therapists are seduced when they assume this missing family member's role; at this point the therapist cannot leave the family because he/she have come to fill a vital role in the clients way of interacting. To break this unconscious process by clients, your task is to:

(a) Help clients see how this role has sustained them in a homeostatic way of responding to each other; and
(b) Help the clients reorganize the structure of their system to include the missing role.

By assuming one of the professional therapeutic roles described in this book, a therapist can help restructure the clients' system by assigning the role to another member or to several family members. Thus, the clients' family structure will be altered to meet the needs created by the missing family member.

When the role wished for by clients is the same as your preferred professional therapeutic role, the chance of an impasse developing is significantly heightened. You may unconsciously start or continue to play this seduced role ascribed by clients and unconsciously absorb the space of the missing role rather than working with clients to assume the role between or among the members within in the therapeutic system. An impasse results and the clients' change process either stalls or stops.

To move out of this seduced or rigid preferred professional therapeutic role, you may find that a healthy dose of curiosity about your own preferred professional therapeutic role may be what is needed to jumpstart or "Shake-UP" the process. When you think about the eighteen professional therapeutic roles introduced in this book that could be activated to transcend the impasse, you will begin the process of moving yourself and your clients, to a higher level of functioning that can continue to induce change.

This book is unique as it was written from a systemic, cybernetic, structural viewpoint and is distinctive in that it is adaptable for use by most clinical therapists who work with a wide range of presenting client issues.

Specifically, problems presented by clients are approached practically rather than analytically. Stagnant professional therapeutic role patterns within the therapeutic system are identified and addressed so that when an impasse develops, the professional therapeutic role being presented can be identified and shifted. This book presents to the therapist the distinctive recognition that they hold the power to change people or systems and that an impasse can be worked through via altering one's professional therapeutic role. The book encourages therapists to move out of professional therapeutic roles that have become cyclic in nature through the application of cybernetics and via the application of structural therapeutic approaches.

Under the umbrella of systemic theory, two sub-theories serve as a further foundation for the text, namely, second cybernetics coupled with a structural approach. Second cybernetics addresses systems within the therapeutic system. The therapeutic system consists of analyzing both the therapist (system) and family (system) together and not the family system alone. The suggested interventions focus on the presenting professional therapeutic role of the therapist in the therapeutic system. By altering the role of the therapist, changes are made in the roles of the other members in the therapeutic system, which helps to deconstruct an impasse.

This book is further connected to the theories and work of Carl Whitaker and Maurizio Andolfi, through recognition that intergenerational influences impact the roles people play in their life (family). There is also a strong connection with the theory of the person as a "living culture" as explained by DiNicola in his book *Stranger in the Family*. The roles that the therapist plays in the interactive exchanges with other "living cultures" are closely connected to the "presenting culture" enacted by clients in the therapy session. The presenting culture is brought forward from the vaster "living culture".

Through the application of structural therapeutic approaches, understanding the life history of clients is paramount for effective change (Haber, 1999). Families are viewed as one system that exists as a subset of larger systems (such as communities and organizations) and contains smaller social subsystems (such as coalitions) within its boundaries. Family structure, subsystems, boundaries and the resulting interconnections are of particular significance in evaluating the functionality of the client's patterns. Identifying the hierarchy among individuals, subsystems, coalitions, and the rules that govern all interactions is also part of understanding and helping a given client. Families may be comprised by these subsystems (spouse, parental, sibling) and operate either according to generic (typical, expected, hierarchical) or idiosyncratic (irregular, unexpected) family rules.

This book presents to its readers a more contemporary way of understanding and explaining human behavior. Systemic theory shifts away from the biological and

psychoanalytic models which advocated a casual, linear model of understanding human illness by analyzing client's in their social context. Rather than endorsing the psychoanalytical viewpoint for the development of an impasse within a session which often blames the *client*, to analyzing the presenting professional therapeutic role of the *therapist*, impasses are viewed as a product of the professional therapeutic role being employed by the therapist in response to the client's seduction.

When therapists assume responsibility for the impasse, they are able to easily shift from one professional therapeutic role to another, and an alternative space within a session is created for new conversations. This new conversation will help clients and the therapist shift out of an impasse and into the creation of therapeutic approaches that will produce healthy changes for the clients (The Shake-UP). By changing the professional therapeutic role, or the "presenting culture", in sessions, therapists promote change in the presenting culture of the other members of the therapeutic system. By enlarging the presented patterns in their dynamic, "living culture", members of the system become more flexible and enriched.

The content within the book is provocative and will encourage you to reflect on your personal growth and development as you re-think your positions within a therapeutic session. The reflection section of each chapter is designed to encourage a deep reflective process in the reader, challenges current therapeutic positions, and thereby promotes long-term professional development. Finally as the book is written from the viewpoint of both a psychologist, psychiatrist, and edited by Kenneth L. Miller who is a licensed professional clinical counselor and certified as a medical psychotherapist, the text is applicable to a broad range of mental health professionals (e.g., psychiatrists, psychologists, counselors, medical psychotherapists and clinical supervisors) who provide psychotherapy services from an interactive viewpoint and is accessible for immediate use.

The book is an easy read and can serve as a carry along reference guide for mental health practitioners. The content will help you to begin to analyze not only your professional therapeutic roles but also your roles within your own family of origin and social circles. When professionally engaged, you will learn how to easily visualize when you are employing a particular professional therapeutic role. Through an examination of both your own patterns of behavior and the needs of your clients, you will be able to see how it is possible to be seduced into filling a specific professional therapeutic role. This knowledge will help you to move freely between the various professional therapeutic roles as necessary to meet the needs of clients. Further, the text includes descriptions of how operating in a particular professional therapeutic roles can specifically lead to an impasse with various client types. Because the roles are created from recognizable visual images, the material is easily imprinted and

transferred into therapeutic sessions. Finally, the case studies and applications are realistic and sometimes humorous, making the text readable and compelling. All case studies were actual cases presented to the authors. Actual names of individuals have been removed to conceal identities.

The professional therapeutic roles described in this book are the:

Angel, Archaeologist, Bird Watcher, Clown, Construction Worker,
Detective, Doctor, Firefighter Journalist, Judge, Mediator, Preacher,
Referee, Sailor, Savior, Secretary, Superman, and Teacher

Of course there are many other professional therapeutic roles that can be assumed, but the professional therapeutic roles described in this book are those most frequently employed by seasoned and beginning therapists within a session. The professional therapeutic roles identified above can dramatically impact the way in which you interact with, gather information from, and intervene on behalf of a client. Of note, the professional therapeutic role that you engage in may often be automatic (i.e. coming from an unconscious level).

Each chapter will guide you into a higher level of understanding of your own therapeutic professional development, preferred professional therapeutic roles, and those professional therapeutic roles to which you can shift when an impasse develops. Of special note, throughout the book the authors use the terminology of *clients* to mean one or more persons within a therapeutic session. In addition when referring to a therapist, the word *he* or *his* refers to both genders.

All together, the purposes of this book are to:

(a) Help you identify through personal reflection and self-awareness, the type of role that you have assumed from a developmental stand point within your own family and within other social settings as you grew up;
(b) Provide a discussion of a number of professional therapeutic roles that you can engage in within a session.
(c) Describe the types of clients that tend to seduce you into using a particular professional therapeutic role within session;
(d) Discuss the type of impasses that can develop between you and your clients;
(e) Identify the risks in which you must engage to get out of a preferred professional therapeutic role;
(f) Identify the client typology where a particular professional therapeutic role and specific techniques might be most effective;
(g) Discuss how to move out of an impasse by changing from one professional

therapeutic role to another; and,

(h) Present a variety of therapeutic techniques or tasks that you can use with clients to transcend the impasse, which is resulting in a lack of client change.

At the end of each professional therapeutic role discussion, you will discover a list of questions that will allow you to reflect on how a particular professional therapeutic role may have developed throughout your personal and professional growth. In each chapter, a case scenario will be presented describing an impasse with clients for whom the therapist has adopted a particular professional therapeutic role. Later in the chapter, a case scenario with discussion will illustrate that by fluidly shifting into another professional therapeutic role, it is possible to shift out of the presented impasse.

Chapter 2 overviews the concept of "living culture" and how this relates to the making of a therapist. This chapter will provide a basis for understanding how "presenting cultures" can influence or hinder the progress made in a session and will particularly describe the influence on the development of an impasse. A discussion is also presented on the structure of the therapeutic system.

Chapter 3 presents therapeutic techniques and tasks that can be used to help you move out of an impasse position with clients. You will be encouraged to redirect clients to alter their structure or organization around a presenting concern or identified patient (IP).

Chapter 4 overviews four main interactional styles that a therapist may employ when engaging with clients in a therapeutic setting and this chapter will serve as a bridging chapter into the various professional therapeutic roles described in chapters 5 through 22.

In chapters 5 through 22, eighteen classical professional therapeutic roles are presented. Each chapter is structured in the same way:

(a) Each chapter begins by overviewing the specific characteristics of a particular professional therapeutic role.

(b) The Positive Use of the Role: Discusses how the professional therapeutic role can be positively enacted with clients.

(c) The Seduction: Impasse Contributing: Provides information about how you can be seduced into a particular professional role by clients' typology.

(d) The Impasse: Provides readers with an overview for how the professional therapeutic role creates an impasse with clients.

(e) The Case Scenario: Presents composites of work with actual clients from the authors' extensive clinical experiences and portrays how a particular (f)

(f) The Risk: Delineates the specific risks you will need to take to breakout of a particular professional therapeutic role.

(g) The Alternative Intervention Style: Impasse Busting: Presents various professional therapeutic roles that could be implemented by you to de-construct a face-to-face impasse with a client.

(h) The Techniques: Presents a variety of techniques or tasks that may be useful within a session or as homework assignments to de-construct the impasse.

(i) The Shake-UP of the Case Scenario: Presents information regarding how the implementation of other professional therapeutic roles along with various therapeutic techniques or tasks actually diffused or (shake-UP) the presented impasse in the chapter case scenario.

(j) The Reflection: Encourages you to examine your own practice in light of guided exercises and questions.

Chapter 23 includes an overview of the impasse process as well as strategies for de-constructing the impasse and selecting a professional therapeutic role. The chapter also includes a discussion of how client information gathered from clients can directly impact the development of an impasse. The "Funnel" concept will be introduced as it relates to how information is gathered through each of the presented professional therapeutic roles. The roles of the Archaeologist, the Clown, and the Journalist will be discussed in relation to the unique way that information gathered from clients is utilized, interpreted and used to create hypotheses designed to facilitate client change. A cross map of the professional therapeutic styles based on level of client involvement and therapist level of control within sessions along with interactional styles can be used as a quick reference guide for moving from one professional therapeutic role to another.

In chapter 24, you will be guided to identify and reflect upon your own "living culture" and your personal reactions to how you respond to a therapeutic impasse. This chapter will help you develop and answer a number of questions surrounding your interactions with family, friends, student life, individuals in social organizations, and with clients. Chapter 24 also serves as a base from which you will begin to identify typical patterns of behaviors that you frequently apply within a session or with family and friends and which will serve as a guide to various classical professional therapeutic roles.

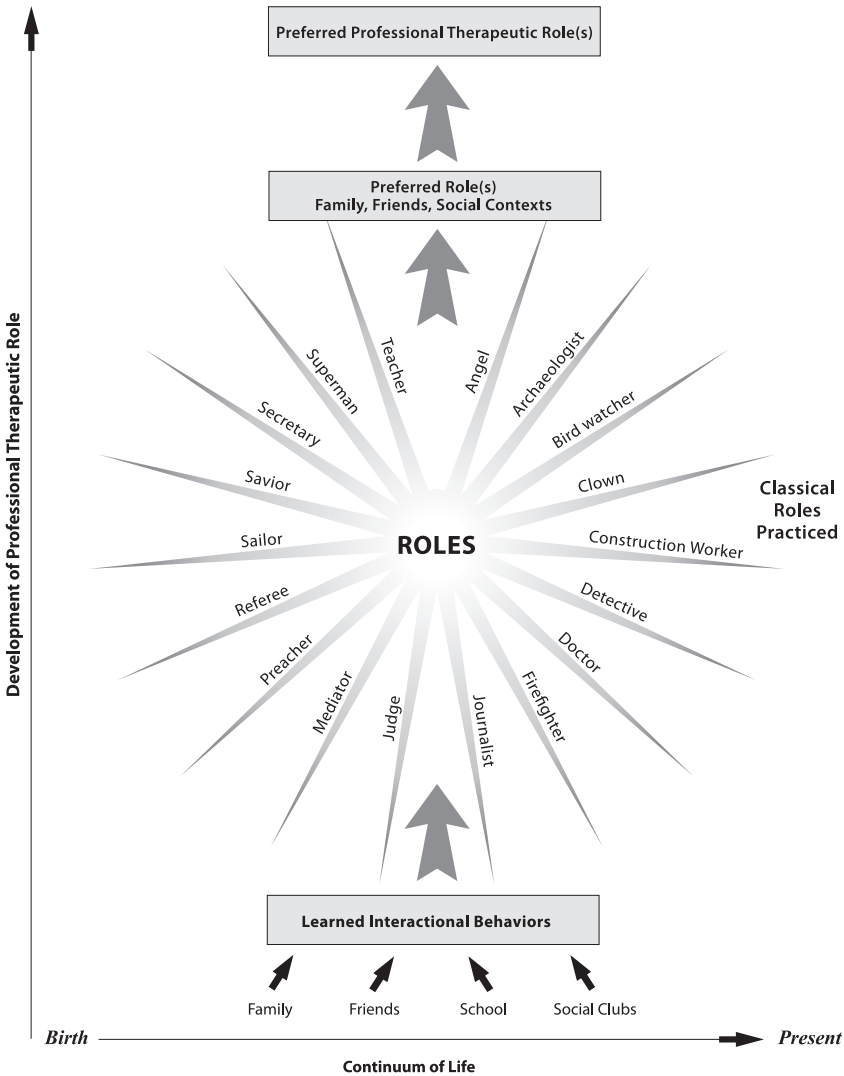
Chapter 25 presents three longitudinal case scenarios that will illustrate strategies that enable the therapist to fluidly shift from one professional therapeutic role to another, bust the impasse, and develop appropriate interventions when working with clients.

Finally, chapter 26 reflects upon the process of the authors' professional development and their preferred professional therapeutic roles and on the process of collaboration on this project and how it changed their professional therapeutic stance in relation to clients, other professionals, and their own personal "living culture."

Making of a Therapist

How you develop your preferred role in specific social interactions is based on interactional roles that you have assumed within a variety of contexts throughout your personal life (see figure one; Development of Professional Therapeutic Role).

Figure One
Development of Professional Therapeutic Role

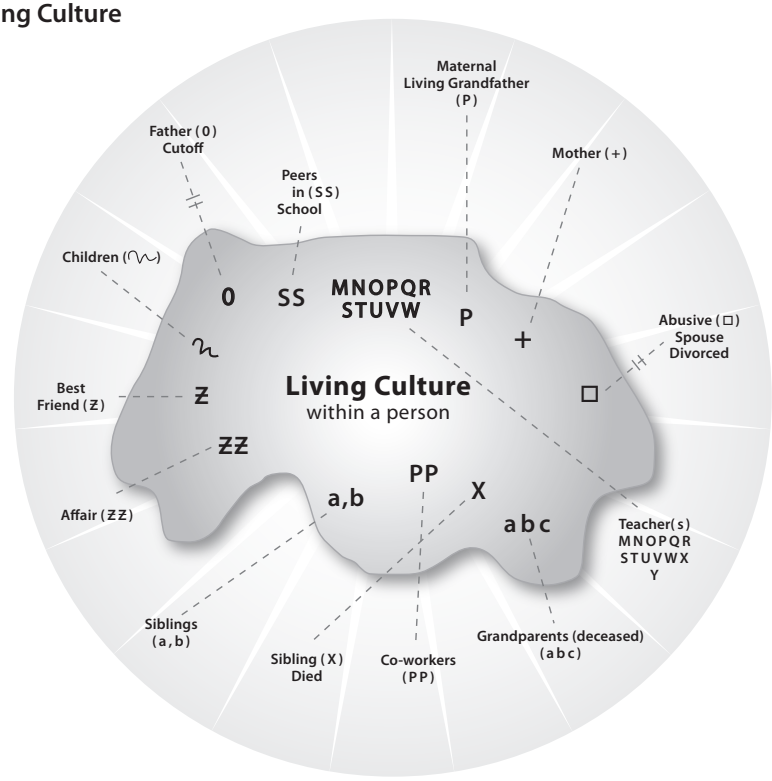


As you progress along the continuum of life from birth to present, interactions with family members, friends, as well as interactions within the school context and participation in social organizations, have helped to shape the preferred professional therapeutic role that you use when engaging with clients.

Throughout the developmental years, you practiced several interactional roles. From these enactments, one or more of the roles became your preferred way of interacting with family, friends, within the school context and/or in social organizations. These roles were developed unconsciously as you received feedback from a variety of people in different contextual settings. These preferred roles or typical interactional patterns were later transferred from your personal to your professional life. Thus, without realizing it, a certain set of preferred interactional professional therapeutic roles are typically and unconsciously employed when working face-to-face with clients.

DiNicola, 1997 referred to the vast array of possible interactional behaviors that you can implement throughout life as your "Living Culture" (see figure two, Living Culture). Each person's "living culture" is highly distinctive and is created via the interactions and relationships that you were exposed to during your lifetime.

Figure Two
Living Culture



The interaction with every family member or individual that has entered and left your life becomes part of your unique "living culture". Therefore, you carry your own "living culture," which is dynamic and constantly changing, based on how your interactions among and between people change. This "living culture" influences how you react and respond to verbal and nonverbal behavior that is received from others. When in a face-to-face context with others, your "living culture" presents itself. Thus, therapists must be cognizant of their own "living culture" as it is carried into each therapeutic session, as well as the "living culture" that each client brings to the session. At any time throughout a session, clients will draw upon the vast, complex dynamic "living culture" within them and create smaller portions of the "living culture" as they react and respond to verbal and nonverbal information from you. Unconsciously, this "presenting culture," selected from the vast "living culture" within each person, will determine the roles (personal and/or professional) that will be assumed in the inter-relational engagement between both you and your clients within a therapeutic setting.

Figure two illustrates how the different subsystems (i.e., mother, father, siblings etc.) interact to solidify certain interactional behaviors that are used throughout your life. These subsystems include other contextual systems that are briefly encountered in your life that are emotionally cut off or no longer present. Thus, this "living culture" or enmeshment of all interactions serves as the backdrop from which you will respond to others.

As you matured and entered the professional realm of life, your preferred roles were again activated. Your preferred "presenting culture" was further enhanced and unconsciously reinforced through your interactions with various professionals and peers at undergraduate and graduate level training in higher education. Academic settings provided an opportunity for beginning therapists to participate in their unconscious preferred professional roles through therapeutic training groups, graduate level practica, and internship experiences. Within these settings you began to learn about various therapeutic theories, approaches, and techniques from which you developed your own professional style for working with clients.

In most clinical training programs, the type of professional therapeutic role, or preferred "presenting" culture in therapeutic encounters that a therapist adopts when working with families is rarely, if ever, discussed. Yet, the behavior and communication style that is portrayed via a particular professional therapeutic role within the therapy setting can have a direct impact on the ability to help clients to change.

The use of the concept of "living culture" and the development of preferred professional therapeutic roles can also serve as a basis for training therapists in higher education mental health programs. Many counseling, social work, and psychology

programs utilize various supervision approaches (e.g., live, internet supervision, tape recorded sessions, mock role plays etc.) to provide feedback to supervisees. One approach that you may have observed or in which you may have participated is the use of a one-way mirror. Through this method, the observing team comprised of peers, mentors, supervisors, and professors, can discuss new professional therapeutic roles, risk-taking behaviors, therapeutic techniques or tasks that can be implemented with the clients behind the one-way mirror. Such evaluative feedback promotes development of candidates' clinical skills, including abilities of the student-as-therapist to shift out of difficult situations or impasses that often develop in training situations. Evaluative data obtained using the one-way mirror method can also be used as a basis for a consultation with another colleague when seasoned therapists experience an impasse.

The process provides a skill-learning maneuver for the therapeutic team behind the one-way mirror. By discussing the various observed professional therapeutic roles, you and other team members can begin to identify areas of "stuckness" within yourself, learn about preferred ways of interacting, and begin to think of other professional therapeutic roles that you may adopt when struggling within a therapeutic session.

Also, a supervisor or co-therapist behind the one-way mirror can introduce new professional therapeutic roles, techniques and tasks directly in this therapeutic process. For example:

> Look at me, a seasoned therapist, sitting in a room together with a family from Pakistan; a mother, father, three sons, and a daughter. Behind the one-way mirror: my co-therapist, along with ten therapists from another facility who had come to learn about our fantastic way of doing family therapy, were looking at me full of expectations. The family presented the problem of the psychotic breakdown of the eldest son. He had reportedly experienced many previous breakdowns and was treated with electroshock therapy in Pakistan and London. In addition, he had reportedly been treated with a variety of anti psychotic medications in Amsterdam. The mother is dressed in traditional Pakistan/Indian silk clothes, the father in a western modern suit. Within two minutes after the session started, the parents had succeeded in assigning to me the role of the "Doctor" as they spoke about the electroshock that previous therapists had given their eldest son in Karachi and London. As the family sat silently, the mother asked me which medication and treatment I would start and what I thought about the diagnosis of "schizophrenia" that had been made by previous professionals. Without thinking, I began to answer her questions. Because the son is often quite angry, the family asked the therapist how to handle the psychotic

behavior at home. At this point, the son shouts at me, "You are Hitler." In response, I try to explain to the son that he has nothing to fear here and I ask him about the voices in his head. Meanwhile the sister and brothers sit on their chairs with arms crossed, staring straight ahead at the wall.

After fifteen minutes the supervising therapist behind the screen enters the room and asks me what I am doing. He exclaims, "Do you know to whom you are speaking? How do you know what they already know and what they need to know? Do you know anything about the culture of this family?

Why are you in such a hurry to teach? Wouldn't it be better first to learn more about the family instead of stepping immediately into the professional therapeutic roles of Doctor and Teacher?"

The supervisor returned to his position behind the one-way mirror. When my colleague left I felt, first, annoyed and a bit angry because he intervened so early and strongly. But after several minutes of silence, I decided to enact the professional therapeutic role of the Archaeologist as I took chalk in hand and I asked for the names of the people in the room. Using the chalk, I wrote the names down on a little black table in the middle of the room. The family had beautiful and exotic names and I asked what were the meanings of the names. Slowly, the entire family began to speak about their heritage and we became involved in a much warmer encounter. In this process we forgot both the time and the symptoms of the eldest son. As we focused on family history even the eldest son changed and answered the questions politely about his name and interests, etc.

The co-therapist entered the room again and said, "The time is up, you have been talking one and a half hours already!" At this point, the father spoke and said, "I want to say just one more thing. Ten years ago, I made the same mistake as you just did. I am the second husband, and the eldest son and daughter are not mine. But when I entered the family of my wife, I immediately wanted to change their behavior. I wanted to be the big helper. Now, after so many years, I realize that I never took the time to really learn about their life before I entered the picture. I really want to come back for another session". The other family members also wanted to return, even the son with the psychosis.

The therapist thanked the father for his openness and apologized for making the mistake, explaining that he could understand the father's rush to help because he also felt the immediacy of the situation. During ensuing sessions, great care was taken to make a family genogram. Over time, the eldest son became much more interested and less anxious during the sessions. The beginning of a strong relationship between the family and the therapist had been forged, which was critical for the treatment of the very serious and complex problems that were present in the family.

Looking back at the initial session I realized that my co-therapist helped to "Shake-UP" my preferred unconscious professional therapeutic roles of the Doctor and the Teacher, which was quickly leading to an impasse. I had been seduced without even knowing it into similar professional roles adopted by previous psychiatrists and the stepfather and the session was heading for failure. In the presence of family members and observers, I was challenged to change my preferred professional therapeutic roles to the professional therapeutic role of the Archaeologist and I took up the challenge. This was a significant step for both the family and myself. When I took the risk to adopt a new professional therapeutic role, it initiated a process of genuine change and movement for the family.

One note of caution: the therapeutic team behind the one-way mirror must be cognizant that these immediate interventions directed toward changing a beginning therapist or seasoned therapist's professional therapeutic role can be very stressful for the therapist, which may cause increased anxiety. Application of direct interventions related to changing various professional therapeutic roles needs to be reserved for therapeutic teams that are very strong or for supervision situations, where high levels of trust characterize the supervisory relationship. Before taking action to change a supervisee's professional therapeutic role during a live therapy session, the supervisor should engage in several role-play scenarios so that beginning therapists can become familiar with the various classical therapeutic professional roles prior to engaging with clients. This will allow beginning therapists to experience what each therapeutic professional role feels like.

After your clinical training, you unconsciously transferred your preferred "presenting culture" into the workplace schema. It is important to keep in mind that the professional role you assumed is similar to how you coped in various social circles as a child, adolescent, and young adult. These roles became the professional therapeutic "living culture" from which you continue to choose to present to different clients. However, one of these professional therapeutic roles can become so engrained, so strongly preferred or felt, that when you begin to experience stress in relation to a particular client, your preferred professional therapeutic role can become very rigid. It is at this point, that an impasse or feeling of "stuckness" may develop both within yourself as the therapist and within the clients. When an impasse develops, clients tend to respond to your rigid "presenting culture" with their own rigid "presenting culture." This will result in therapeutic members of the family becoming defensive in their relations with one another and the therapist. This rigidity often results in therapy ending prematurely and without effective client outcomes.

Within most therapy sessions, you will engage in more than one of the prescribed professional therapeutic roles and presented therapeutic approaches described in the

following chapters. This means that you will be able to actively choose one or more presenting cultures from your total "living culture" when face-to-face with clients. This ability to fluidly shift from one professional therapeutic role and utilize one or more therapeutic techniques or tasks will create a healthy therapeutic style and the ability to interact as well as intervene with most presenting client issues.

You will also be able to adapt to a host of client typologies. Keep in mind that no matter how adaptable you are, there are certain professional therapeutic or personal roles that you will unconsciously assume when experiencing stress with clients. Impasses arise when the tension within a session builds and the professional therapeutic role becomes solidified to the point that this is the *only* way you can interact and communicate with these types of clients.

All therapists will at one time or another experience a particular type of client that will trigger, through seduction, a rigidified therapeutic professional role that results in a therapeutic impasse. During such therapeutic situations you need to recognize that you are stuck in the therapeutic process and realize that you may be engaging in a very rigid and inflexible professional therapeutic role.

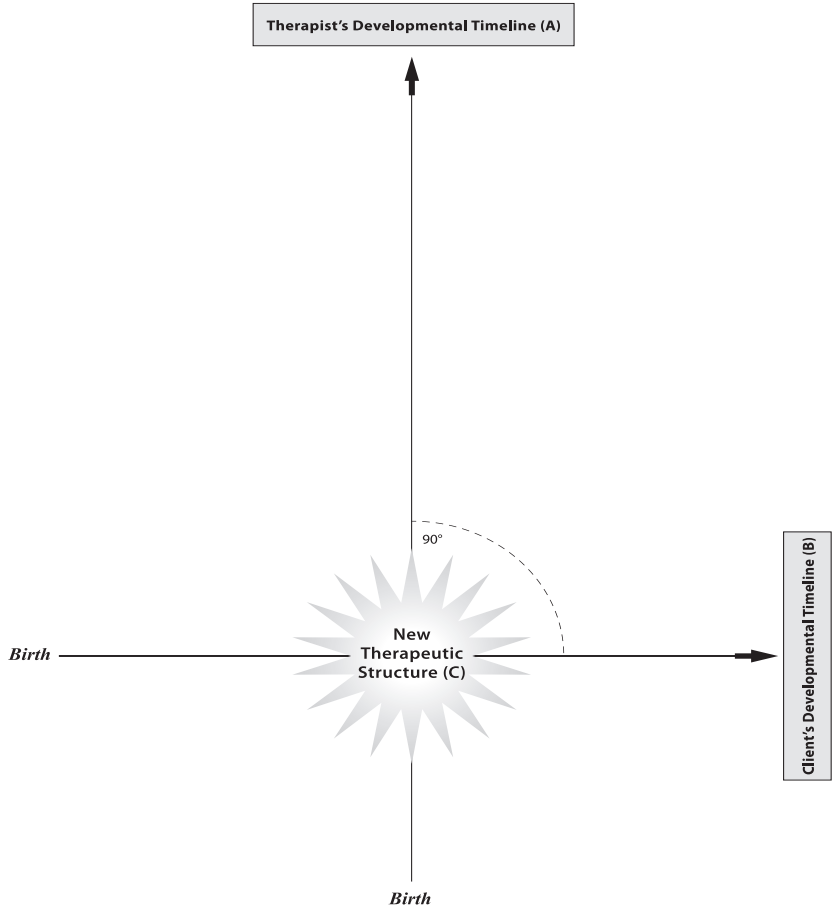
By shifting from your preferred presentation of your "living culture" to another professional therapeutic role, the therapeutic process can move forward. Consequently, it is vital for you to learn how to implement as many possible different presenting cultures from your own "living culture." In addition, it is critical for you to expand the richness of your "living culture" into the context of various therapeutic situations while fluidly shifting in and out of a variety of professional therapeutic roles (see chapter 25).

Structure of a Therapeutic Setting

When a client and therapist meet in a therapeutic setting, each brings to the session his own "living culture," which is the foundation for personal beliefs, values and feelings and which provides a context for communicating and understanding client concerns. Developmental timelines within therapist and client cultures are orthogonal in nature (see figure three, Orthogonal Relationships within a Therapeutic System) and may vary extensively based on a host of biological and environmental variables.

Thus, therapist and client developmental timelines (points A and B, respectively) emerge as a function of personal and professional life experiences. When the therapist and clients meet, these timelines intersect at point (C) and a new therapeutic structure or setting is created. It is at this point in the therapeutic process that a therapist joins with the family in order to achieve various therapeutic outcomes. So in figure three the upper right hand quadrant (see the 90 degrees) which is located just to the right of the therapist's developmental time line and above the client's

Figure Three
Orthogonal Relationships Within a Therapeutic Structure



developmental time line is the point where the new therapeutic structure (setting) takes place and it is from this point that the therapist and client move forward together in space.

Motivations to pursue therapeutic outcomes differ for the client and therapist. According to Andolfi, Ellenwood & Wendt (1993), the client's motivation is centered around "fixing" the presenting symptom of the identified patient (IP) while the therapist's motivation may be more intrinsic and focus on success, enhancing self-esteem and being validated for doing a good job. Yet, all entities enter therapy with the goal of producing systemic change. The therapist choreographs the complex and dynamic therapeutic structure created by intersecting developmental timelines in trust, effective communications, accommodation, and validation of all family members.

Minuchin (1974) described family structure and dynamics as an, "invisible set of functional demands that organize the ways in which family members interact" (p.51). Within the therapeutic system, the therapist also prescribes a structure composed of visible and invisible demands for the transactional and communication behaviors of self and clients. Through his professional therapeutic style, the therapist determines who will relate to whom, when, and in what ways. Simultaneously, the therapist works to promote systemic change by balancing the timing of closeness, distancing, boundary setting, level of orientation with the system, and degree of provocativeness.

Boston (2000) suggested that the structure of therapy is less about the beginning, middle or ending points of a session and more about creating space for a specific kind of conversation between members in a therapeutic session. If one were to observe therapy in action, it would be the point at which clients communicate within this therapeutic space. As such, the structure of the therapeutic setting is designed to encourage clients to share their stories and perceptions of presenting concerns.

Boston further indicated that the therapeutic structure should be characterized by therapist reflectivity. In particular, Boston suggested that the therapist role be examined in light of the manner in which he: (a) imparts questions in order to gather or expand information, and reveal meanings to members of the system; (b) encourages discussion between clients; and, (c) determines who is allowed to speak to whom and under what circumstances. The therapist's primary contribution to the process of change lies in the construction of a particular professional therapeutic style conveyed within a session. Within the session structure, the therapist may elaborate and embellish themes from the session or work to reduce or refocus client communications. The therapist's professional therapeutic interactional style will guide him in joining the family, asking probing questions, promoting distance or closeness, using self within a session, and determining how client information is conveyed.

The eighteen professional interactional roles described in this book are designed to help therapist's determine how their preferred interactional styles either collide with or mirror those of their clients. After reading this book, therapists will be able to determine the influence of their preferred style(s) on systemic change. Although the adoption of some styles may generate opportunities for client growth and more productive family functioning, therapist reliance on a preferred style or role may severely limit systemic changes. As such, the structure of the therapeutic setting must be assessed in addition to professional therapeutic interactional style (see chapter four for more details) when therapy comes to an impasse.

In order to assist the therapist in exploring these dynamics, the following reflection questions are provided.

(a) How does your professional therapeutic role and interactional style promote or limit attainment of client goals or promoting systemic change?
(b) In concert with your professional therapeutic role, does your therapeutic structure overpower or underwhelm clients?
(c) Are you willing and able to modify your professional therapeutic role as required by the unique clinical needs of both individuals and family members?
(d) How would your client describe your preferred professional therapeutic interactional style and are these descriptors consistent with your self-assessment?

Chapter 3

The Use of Directive Tasks in Therapy

Clients who come for therapy are looking for direction on how to improve a situation in their life, yet they often do not know how to activate inner resources to make necessary changes. Consequently, clients sometimes feel hopeless, lost, or depressed. The therapist assumes the role of one who can assist a distressed client by providing understanding and guidance that can gently lead him to positive change. However, therapists also know that merely understanding a symptom or situation will not induce clients to change their particular role around the presenting concern. Therapists must be willing to provide directives to clients who, with practice, can master new interpersonal skills with the goal of creating permanent change. Ideally, such directives provide clients with opportunities to explore alternative modes of cognition, affect, and behavior toward presenting concerns, as well as a measure of flexibility to restructure their responses to the presenting concerns. Restructuring a system is not a new concept. Wittgenstein (1956) reported that mere insight is not the goal of restructuring; rather the goal is to teach a new game, a new response, so that the former behaviors around the symptom lose their appeal.

In order to understand the concept of change, Andolfi (1980; 1983; 1989) espoused that change was more than the resolution of symptoms for an individual. Change encompasses all members within a system by offering them transactional models that eliminate the need for the symptomatic behavior. Andolfi viewed symptoms as a signal of a disturbance in communication among and between members of a system. One way to produce needed change is to create transactions through the use of various therapeutic techniques or tasks in which clients participate within or outside the session. The purpose of therapeutic techniques or tasks is to guide clients in the practice of less rigid structures around the presenting concerns. They are the vehicles or tools that can be employed by a therapist to help alter the therapist's professional therapeutic role which will assist in breaking of an impasse with clients.

A variety of therapeutic techniques or tasks can be utilized to create healthy change for clients. Throughout this book, the authors will describe various professional therapeutic roles that can be adopted to deconstruct a therapeutic impasse. They will further identify various therapeutic techniques or tasks that accompany each professional therapeutic role to help therapists reinforce and produce a situation where it is safe for clients to engage in new transactional patterns around presenting concerns. The therapeutic techniques an tasks discussed in this handbook are

not presented as a means to an end; rather the techniques should serve as a catalyst for the creation of client-specific approaches or therapeutic techniques that will facilitate desired change.

Therapeutic techniques or tasks, should be formulated from information that is gleaned from clients about their presenting concern, family of origin history, cultural milieus, verbal and nonverbal interactions within a session among and between clients, level of enmeshment or disengagement and from information imparted by the clients about how they respond (i.e., cognitively, emotionally, behaviorally) toward the identified patient (IP) or presenting concern. In task setting, the therapist prescribes an activity to be carried out within a specified time limit. Tasks can be direct or indirect, developed for all members present or a single member in the session. Ultimately, the task should create opportunities to showcase flexibility so that the role of the IP or the presenting situation is not context specific. In this way, a context is developed that highlights a collaborative atmosphere wherein rules and individuals are respected and new communication levels are employed. Feedback as to how the clients are successful or unsuccessful in carrying out assigned tasks provides valuable information to the therapist (e.g. regarding the individual members' level of resistance toward change or who within the therapeutic system sabotages the assigned task when change is attempted). However, when clients do not complete an assigned task it is useful for the therapist not to view this lack of completion as "resistance" or "sabotage." Instead therapists may more accurately interpret such responses as failures to obtain sufficient information or understand well enough the complexity of the system when he assigned the task. So-called, "resistance behavior" displayed by the system must be interpreted by the therapist as an opportunity to obtain additional information and implies that more effective therapeutic interventions need to be created for this system.

Types of Therapeutic Techniques and Tasks

The therapeutic techniques and tasks described below have been adapted from Gurman & Kniskern, eds (1991) and Andolfi (1978). The authors are aware that there are many newer therapeutic techniques and tasks that can be used to produce change with clients. However, the techniques presented below are foundational approaches that have demonstrated efficacy across time, settings and systems.

Accommodation: The therapist accepts the rules and types of communication that govern the relationship between and among clients as presented by the clients. This allows the therapist to join with the client, enter their network, and set the stage for inducing change.

Adding systems: The therapist increases the number of people present within a session to expand the amount of information that can be collected regarding maintenance of a particular symptom. Adding systems will also help to enhance the availability of resources to clients (Haber 1987; 1994).

Altering the affect around the symptom: The therapist alters the impact of the symptom, thereby relieving the emotional response that is causing anxiety for clients. This technique promotes greater client flexibility so that restructuring of the system can occur.

Blocking transactional patterns: The therapist actively prevents clients from relating in their habitual patterns of interaction. This action will create a situation wherein clients must seek out and practice alternative ways of relating to each other.

Circular questioning: This technique was introduced by Peggy Penn (1982) in the USA,The Milan group (Selevin-Palazzoli, Prata, Cecchin, & Boscolo) in Italy and Karl Tomm in Canada. Although an "older" technique, it is extremely valuable when working with couples or families. The simplest way to use 'circular questioning' is to ask one partner or someone in the family what another person thinks about the relation between other persons, or how he/she thinks another person feels about a particular issue. These questions help each person in the therapeutic system to think about the presenting issue from another person's perspective and to place it in an interactional context. (Tomm,1987a; 1987b; 1988); Selvini Palazzoli, Boscolo, Cecchin, & Prata, 1980). The Milan therapists held the belief in later years that circular questioning alone could change the interactional patterns between members in a therapeutic setting. However, despite evidence of its clinical usefulness, current thought suggests that the use of circular questioning alone is too rigid when isolated from other therapeutic techniques.

Constructing patterns: The therapist believes that clients lack the appropriate structure and uses instructional approaches within the session to help create and solidify a new organization and structure for clients.

Contextual tasks: Applied by a therapist in the actual therapeutic session, these tasks are employed when a therapist wants to change the emotional atmosphere within a therapeutic setting.

Countersystemic tasks: The therapist creates a context of accusation or competition in order to undermine and oppose the homeostasis in client systems.

De-emphasizing the Symptom: The therapist, purposefully does not provide any level of significance to the presented symptom(s). By de-emphasizing a symptom, the energy around the symptom is depleted and renders it useless to clients.

Developing Implicit Conflicts: The therapist emphasizes hidden differences among clients while simultaneously highlighting and exposing the suppressed reasons for these differences. This allows the therapist to make client differences overt, thereby increasing tensions within and between clients that expose their habitual patterns of relating.

Dissembling tasks: The therapist actively disassembles those features within a context that are perpetuating a symptom(s). This technique is designed to promote client flexibility and provides opportunities for the therapist to analyze the system for the purpose of realigning power and boundaries within the clients' world.

Displacing tasks: The therapist artificially assigns the presenting problem to another client within the session. These therapeutic tasks are employed when clients have identified a scapegoat (i.e., IP) within the therapeutic system. This approach encourages clients to move away from their rigid, abnormal relational patterns to alternative roles and patterns, thereby creating movement within clients and freeing the scapegoat from his long-standing rigidified role.

Emphasizing differences: The therapist makes overt the hidden differences among clients. This allows explicit conflict between others to surface and the true organization of interrelation patterns around a presenting concern to be exposed.

Exaggerating the symptom: The therapist, resolutely exaggerates a symptom to the point where it no longer serves a purpose for the clients. Through this process the therapist renders the symptom ridiculous and useless.

Family genogram: A family genogram is a graphic representation of a family tree that displays detailed data on relationships among clients. It goes beyond a traditional family tree by allowing the therapist to analyze hereditary patterns and psychological factors that punctuate relationships. Family genograms allow a therapist and clients to quickly identify and understand various patterns in the clients' family history, which may have had an influence on the clients' current state of mind. The genogram maps out relationships and traits that may otherwise be missed on a pedigree chart. A creative way to expand the genogram is to create special focused genograms. For example an Illugram, is a genogram with drawings in it. A Somatogram is a genogram where through a metaphorical way every person in the therapeutic system is connected with an organ in the body (e.g., stomach, bowls, ear, lungs, heart, etc.) through which nonverbal somatic complaints are expressed. This type of genogram is best used with people who come to therapy with just somatic complaints. A Culturogram, is often used with multicultural families and focuses on the different cultures and places where the clients in the therapeutic session come from. For example flags from the different countries or states can be drawn to represent the homeland of each member. An Addictogram is where you add in

little drawings for every person in the therapeutic system to depict the preferred addiction they use as a solution for lowering their pain level (for example a bottle for alcohol, a cage with medication, cigarettes, hash, cocaine, etc). The nice thing about genograms is that you can be creative and develop your own special genograms with specific families.

Feedback: By providing feedback, the therapist shares perceptions of how clients' interactional and behavioral patterns are being viewed.

Highlight Differences: Through the use of these techniques, the therapist emphasizes differences among the therapeutic members in order to help create a sense of individualization and to reduce enmeshment in the family system.

Homework: Tasks that therapists assign for the therapeutic members to complete between sessions. Homework tasks are often used to reinforce newly learned transactional patterns in a session.

Humor-is a very powerful and provocative tool that therapists can employ to redefine and reframe the presented problems and behaviors in a way which will help to remove the tensions which are present among clients. Humor can allow all members of the therapeutic system to look at their behavior, prejudices, and world views from another perspective. However, humor must be used with caution as clients can become insulted or angry if the therapist minimizes their situation too much.

Maintenance: The therapist maintains the integrity of clients' interactions and does not challenge nonproductive interactions. This provides a base through which a therapist can join a system and then induce change at a later point in therapy.

Mimesis tasks: The therapist adopts a client's manner of communication (e.g., body language, speech tempo, etc.). This approach provides a base through which a therapist can join a system and induce change at a later point in the therapeutic process.

Metaphorical tasks: When clients' communications present as rigid and defensive in nature, a therapist implements the use of objects, directives, and homework assignments within the session to communicate both a literal and an abstract message regarding communication dynamics. This type of communication can be dramatic as it helps to produce insight for clients regarding their rigid state of communication (Haber, 1986; 1987).

Move to a new symptom: The therapist attracts client attention away from the presenting symptom to another symptom where the clients are less rigidly organized. This approach debilitates the maintenance of the old symptom and allows the true infrastructure of clients' interrelations to surface.

Negotiation techniques: Communication methods or tasks utilized during a session to teach client negotiation skills.

Paradoxical tasks: These therapeutic tasks are useful when clients present double bind situations wherein they say one thing but actually mean another. Paradoxical tasks are used by the therapist to interrupt a vicious communication cycle that conveys they do not want help, a therapist can accept this double bind communication, placing the therapist in a different position than clients expect. The end result can lead to clearer communication among clients and therapist.

Prescribing the rules: The therapist tends to provoke infractions upon the clients' rules that helped to create and maintain presenting symptoms. These techniques help to break the rigid, dysfunctional rules that maintain homeostasis (or equilibrium) in clients and family systems.

Prescribing the symptom: This paradoxical therapeutic technique is used by a therapist when a request is made to the clients to either reinforce, continue, utilize, or even intensify a symptom. If a client (IP) is able to enhance the presenting symptom, the therapist and other clients may understand that the IP is in control of the symptom and that it is not involuntary. Through this process, affect around the symptom is altered and clients gain insight into their power over the symptom.

Provocative Techniques: These therapeutic tools can be used with highly resistant clients to bring about change. Although these techniques often employ the use of humor, the therapist must use them cautiously. Provocative techniques mock clients' behaviors and or situations that can be interpreted by clients as malicious personal attacks.

Puppets: Puppets are useful therapeutic tools when clients are unable/hesitant to speak or following a traumatic experience. Puppets may be particularly useful with children who are preliterate or who are unable to attach words to personal experiences, particularly those of a traumatic nature.

Reinforcing patterns or tasks: These therapeutic tasks allow a therapist to maintain structures or patterns that are displayed by clients in order to enhance their interactional patterns of behaviors. These tasks are used to strengthen clients' current interactional patterns that are effective in producing change.

Relabeling the symptom: The therapist redefines the symptom as a positive sign by presenting an alternative interpretation to the clients. This approach creates opportunities for new interactions between and among clients and allows the therapist to discern the structure of client patterns behind the problem of the symptom.

Reorganizing patterns: The therapist becomes aware that clients have resources available to them that could provide assistance in dealing with the presented problem, but which are not being accessed or utilized. Helping clients to reorganize their family structure through the use of genograms may bring to light useful patterns and help to eliminate conflicting ones.

Role-Playing: Clients are encouraged to act-out various life situations related to presenting problems or their resolution. Role-playing is an exceptional tool for clients struggling with a variety of issues. When given the chance to "act" in an unfamiliar role, whether as self or other, new, even life-changing ideas can emerge.

Structural tasks: Techniques that are designed to help move clients from a dysfunctional to a more functional role or position within the system. Structural tasks are an invisible set of functional demands or rules that organize ways in which family members relate to one another.

Subtracting systems: The therapist decreases the number of clients present in a therapy session for the purpose of eliminating abusive and other dysfunctional behaviors so that more information can be collected from clients without interruptions.

System restructuring tasks: The therapist actively restructures habitual communications among clients by substituting new and more functional communication patterns within the session.

Talking stick: As the name implies, a talking stick is a long stick produced by the therapist and is labeled as such for clients. This tool is designed for use when clients habitually interrupt therapy sessions. Only the client holding the "talking stick" is permitted to speak.

Tasks of alliance with the symptom: These therapeutic tasks are primarily utilized when clients are in a transition phase of their life and are particularly useful for clients who have adolescents beginning their journey to autonomy. The therapist provokes a symptomatic behavior with a client and simultaneously supports the behavior, which develops around the supported symptom in order to induce change within clients.

Tasks of attack on the symptom: The therapist purposely attacks the symptom to the point where the symptom looks ridiculous. A note of caution: when therapists attack a symptom, they need to balance areas of autonomy to protect and strengthen the identified client. A therapist needs to remember that a symptom carries with it manipulation and personal power which, if implemented poorly, may actually do more harm than good for an IP.

Tracking: The therapist adopts the client's symbols (e.g., language, life themes, client values, timelines, etc.), with the goal of enhancing communication with clients.

The above therapeutic techniques or tasks can help a therapist join a family, restructure clients' transactions, and promote shifts in clients' power, organization, structure to more productive positions and break impasses. Skilled use of these therapeutic techniques or tasks can result in symptom reduction and the elimination of scapegoating behaviors. Effective clinical practice using these techniques provides

clients with opportunities to learn more effective communication and interaction skills, thereby enhancing personal development and strengthening clients' systems.

Chapter 4

Matching of Interactional Style to Preferred Professional Therapeutic Role

Prior to examining the eighteen professional therapeutic roles described in this book, therapists are encouraged to reflect on their personal interactional style. It is important to note that such styles have evolved from unique life experiences and have been unconsciously adopted and implemented in various familial, social, and therapeutic settings. During this reflection, pay particular attention to interactional behaviors that emerge in conflicted situations or when an impasse develops with clients. In this self-examination, carefully consider the following questions: (a) how involved do you become with clients/family systems?; and, (b) what level of control do you display when working with clients?

Interactional Styles

Each therapist develops a personal interactional style of relating to clients. According to Koenig (2001), professional therapeutic style is as unique as someone's fingerprint and as distinctive as a voice or a gait. The therapist's interactional style forms a backdrop from which the client's historical information is revealed. Although this interactional style is instinctive and only part of the therapist/client dynamic, it plays a crucial role in establishing rapport and obtaining critical information about presenting concerns. Koenig suggested that therapists who explore their interactional style may reflect on abilities to connect, empathize, diagnose, and intervene effectively in clients' systems; those not taking this step may underestimate the impact of their interactional style on session dynamics and therapeutic outcomes.

Koenig suggested that interactional style is a descriptor of how a therapist will act during the therapy hour. It is a product of his theoretical orientation and experiences with client populations (e.g., couples, addicts, families, children, gay and lesbian clients, etc.). Interactional style is also derived from areas of clinical expertise such as dissociation, trauma, chronic illness, addiction, divorce, and other specialized issues. The therapist's theoretical orientation and areas of expertise interact continuously within the structure and dynamics of the client's personality, beliefs, and values. Taken together, these dynamics help to define a therapist's clinical persona and his selection of treatment approaches. Koenig further elaborated that interactional style is derived from experience, heredity, and unique individual characteristics such as

talents, aesthetic taste, physical strengths, weaknesses, appearance, education, intelligence, disposition, and sense of humor.

By examining adherence to the following interactional styles, the therapist may gain insights into clients' perceptions of his effectiveness. He may further discern professional therapeutic roles consistent with his style and opportunities to expand upon preferred therapeutic roles should impasses develop. Familiarity with these interactional styles provides information to inform the productive use of a professional therapeutic role and suggests how over-reliance on a particular style may signify needs to tailor, adjust, or select an alternative professional therapeutic role.

Figure 4, Professional Therapeutic Interactional Styles, overviews the four most common interactional styles employed by therapists within the therapeutic session (Need to Intellectualize, Need to be Curious, Need to Control and Manage Information; or Need to Save others) and which are further described below. At any time a therapist can move into another interactional style with clients but most therapist have a preferred interactional style that compliments their preferred professional therapeutic role.

Interactional Style: Need to Intellectualize

In reflecting on your interactional style, you may believe that the most important aspect of your client interactions has been to provide an educational experience. By embracing this style, you have worked hard to create a clinical environment in which clients learn about their relationship dynamics, limitations, and strengths, all of which provide opportunities to resolve problems and create a more functional family system. If a client appears to be lacking in knowledge or understanding an issue, you are quick to impart knowledge or provide the necessary resources (e.g., books, online sites, etc.) to promote awareness. You believe that intellectual growth and achievement are continuous throughout the lifespan. You rely on your intellect or medical verbiage to identify what is good for clients. You international style includes imparting universal principles, beliefs, and morals unto others. If your interactional style is based on a need to intellectualize, begin by reading chapters eleven, fourteen, sixteen, twenty-one and twenty-two; the therapeutic professional roles of *The Doctor, the Judge, The Preacher, The Superman* and *The Teacher.*

Interactional Style: Need to be Curious

Reflecting on therapeutic responsibilities may lead you to think that one of the most important aspects of your interactions with clients has been to help them understand the underlying dynamics of their presenting problems. In adopting this interactional style you have worked hard via questioning to carefully gather

historical artifacts, data, clues, and information. You believe that you have the resources necessary to uncover hidden information and you gather documentation through a number of resources. If you find yourself helping clients uncover their family history or secrets, frequently asking probing questions, and searching for details, you may benefit by reading chapters six, ten and thirteen or the therapeutic professional roles of *The Archaeologist, The Detective, and The Journalist.*

Interactional Style: Need to Save Others

In pondering your way of working with clients and family systems, you come to believe that the most important aspect of your interactions with clients has been to guide, strengthen, assist and encourage them. You also strongly believe that a primary goal of your interactions with clients has been to help resolve a desperate or intense situation for them. You may even use colorful comments, jokes, and other forms of humor to make clients happy. By adopting this interactional style you have worked hard to provide for, protect and deliver clients from their losses, depression, and emotional wounds. You use communication skills to reassure others that you can and will save them. If these characteristics are consistent with your interactional style of needing to save others, consider reading chapters five, eight, twelve, and nineteen; the therapeutic professional roles of *The Angel, The Clown, The Firefighter* and *The Savior.*

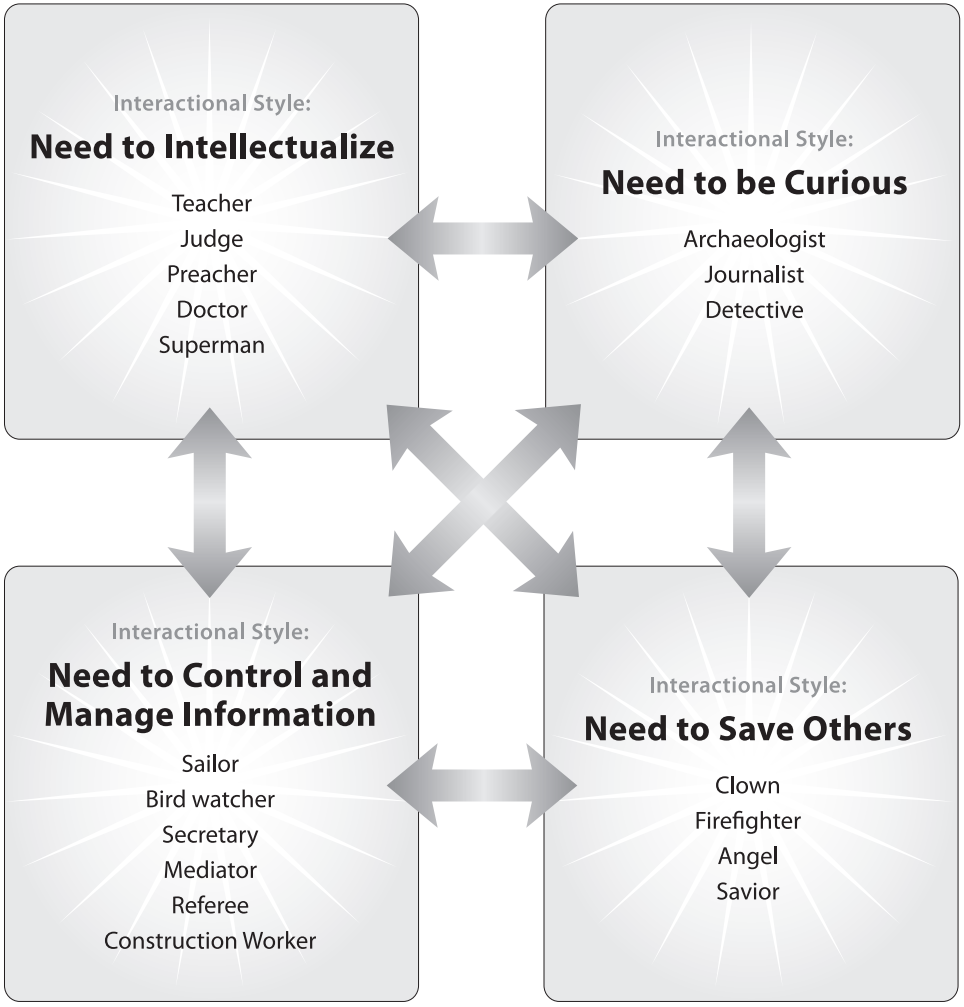
Interactional Style: Need to Control and Manage Information

Self-reflections of your therapeutic work lead you to think that: (a) the most important aspect of your interactions with others has been to control who speaks to whom and then make decisions as to how others should behave or what actions they must take in order to solve a particular situation; or, (b) you have trouble controlling information and knowing how to get control within a therapeutic session, especially when too much information is communicated in a short period. Adherence to this interactional style has caused you to focus clinical energies on monitoring, watching, and documenting the actions of others. You believe that the most important aspect of your interactions with clients has been to facilitate equitable solutions. In attempting to manage information, you work hard to listen, sort through differences between individuals involved in a disagreement, and develop solutions for clients.

If you are aware of personal control issues related to managing other's behaviors, you observe that your interactional style involves being silent, observing, recording, or writing down clients' struggles for later analysis. You may even panic when confronted with too many clients at one time or too much information. This style requires you to function by either under-reacting, observing, and watching every move, or over-reacting and responding too quickly. If your interactional style

involves the need to control, you may find value in reading chapters nine, fifteen, and seventeen; the therapeutic professional roles of *The Construction Worker, The Mediator, or The Referee.* If you struggle with a need to manage information, consider reading chapters seven, eighteen and twenty: *The Bird Watcher*, *The Sailor* or *The Secretary.*

Figure Four
Professional Therapeutic Interactional Styles



Part Two

The Professional Therapeutic Roles

The Angel

Chapter 5

Chapters 5-22 explicate eighteen professional therapeutic roles therapists may adopt in working with clients. Of course, there may be other professional therapeutic roles that a therapist has adopted in clinical practice. This book will describe the professional therapeutic roles that are most typically utilized. In reviewing these chapters, the reader is encouraged to carefully examine those professional therapeutic roles consistent with one's interactional therapeutic style. The reader is further encouraged to visualize his practice with various individuals, families or couples and to be cognizant of the circumstances in which a particular professional therapeutic role is adopted. Of particular importance is the goal of identifying preferred professional therapeutic role(s) when tensions or conflicts develop within the therapeutic system. Table 2 provides a quick reference guide for each of the professional therapeutic roles described in this book. This chapter we will address the professional therapeutic role of:

The Angel

Ah, the Angel, the interjector of hope, the person who relieves all pain, hurt, and sadness in others. The Angel therapist assumes a role of wanting to please all clients in the session. Throughout the session the Angel guides, protects, reveals positive insight, strengthens and encourages clients. The Angel is viewed by clients as being a kind and lovable person. Through the client lens, the Angel personifies goodness, purity, and selflessness. The Angel's primary unspoken message is one of hope as the therapist imparts what is best for each person's needs. In this professional therapeutic role, the Angel will offer advice designed to subdue conflict in the session and work very hard to suppress or eliminate tensions within the family system.

Positive Use of the Role: The professional therapeutic role of the Angel is positively enacted when conflict is high and confrontation is the main style of interaction among the clients. The Angel therapist introduces hope, calmness, and peace in a session so that the clients can begin to relate to each other on a different interactional level. The Angel helps clients to examine positive elements of their relationships.

The Seduction: Impasse Contributing: The Angel is seduced into action by clients who come to therapy looking for someone who will not confront them and who will avoid conflict at any cost. Such clients often present with conflicts that underscore presenting symptoms, but who are unwilling to discuss these conflicts. When the therapist is seduced into enacting this role, he is loath to inflict pain and may, indeed,

help clients avoid tension. However, such avoidance will exact a heavy cost for both clients and the therapeutic process. Although the Angel breathes perpetual hope and comfort into sessions, his behavior unconsciously contributes to an impasse.

The Impasse: The Angel does not allow conflict to surface. Consequently, the underlying cause of the presenting symptom is not uncovered. Although both the therapist and clients seem to be pleased with therapeutic sessions, and especially the Angel therapist, change client change cannot occur because the root of the problem is avoided. Typically, clients will remain in therapy for a long time. Even though clients may express concern that the presenting symptom is not changing, they are pleased that underlying conflicts remain buried, and the interjection of hope encourages them to continue in the therapeutic process.

The Case Scenario: Twelve-year old Bobbie reports stomachaches and being very tired all the time. All medical tests are normal. Bobbie does very well in school, even though he is periodically absent due to stomachaches. No teacher complaints are noted and he appears to have many friends. In school, Bobbie's stomachaches seem to disappear, but reappear each night around dinner time and in the morning prior to leaving for school. The primary physician encourages the family to seek counseling based on a clinical hunch that the stomachaches are symptomatic of unresolved emotional problems. Based on parental and medical reports, the Angel therapist determines that no serious medical issues are apparent and focuses on causes of the stomachaches. A number of therapeutic sessions are held with the parents, Bobbie, and younger twin siblings. Most of the discussion focuses on Bobbie's presenting symptoms.

The Angel therapist develops several interventions, and the family dutifully carries out the prescribed tasks. The therapist requests that the parents serve small portions of food to Bobbie over several hours rather than during a single meal. To deal with exhaustion, the therapist suggests that Bobbie go to bed an hour earlier each night, except on weekends. The bedtime routine for all children is amended, with both parents engaging in the nightly routine. Dutifully, the parents follow the Angel's recommendations. To everyone's dismay, Bobbie's stomachaches continue and his exhaustion is getting worse. With each session, the Angel reassures the family that the stomachaches will stop; they just need to find the "right" cure. This therapeutic stance interjects hope into the family system.

After a few sessions, the family and the Angel become stuck as Bobbie's stomachaches and exhaustion increase in intensity and duration. The Angel and family are at an impasse. Even though the presenting problem does not change, the family stays in therapy because they feel safe with the Angel. In individual sessions, the

couple skillfully masks their conflict and differences. Sensing a deep-seated conflict in the family but being highly uncomfortable with allowing the conflict to emerge, the Angel continues to interject hope and consolation while neglecting to explore underlying factors that hold the promise of creating the understanding necessary for family members to resolve the conflict.

The Risk: If you find yourself enacting the role of the Angel, it may be necessary to practice making clients *un*comfortable. This is extremely risky, because the Angel is eager to please everyone, especially himself. If clients are too comfortable in a session, they will not change and homeostatic functioning of the family system will be maintained. You will need to let tension rise in a session so that the behavior patterns around the presenting concern can be identified both verbally and nonverbally. Keep in mind that the Angel therapist desires peace and happiness for all clients; therefore, tension is especially difficult. In addition, you may freeze and not know how to respond to clients who present anger, pain, grief, sadness or depression. Consultation with a colleague may be helpful to provide encouragement and training to gain comfort with tension that develops in sessions and to engage in new interventions and therapeutic approaches to move the client out of impasses. In this way, the Angel may avoid relapsing into the seduced role. When at an impasse, the Angel must shift from the safety of the symptom to interactional relationships so that underlying dynamics of the client's structural organization can be revealed, recognized, and resolved.

The Alternative Intervention Style: Impasse Busting: There is a number of therapeutic professional roles that the Angel can utilize to deconstruct a face-to-face impasse with a client. The role of the Archaeologist allows you to gather relational information around the symptom. This information can be used to analyze areas of discontent and stress in client roles and relationships and may be helpful in restructuring personal and family systems. The Bird Watcher role may be particularly helpful as you register clients' nonverbal interactions as well as vocal intonations that are inconsistent with the intended meanings of communications. The role of the Detective would help you dig deeper into family relations in order to move beyond the superficiality of client communications. The professional role of the Clown would be useful in moderation when tension appears in the session and may bring creativity into the session. Members in the therapeutic session would see that tension is safe; when tension becomes too stressful, humor can be interjected to provide temporary relief, but not distract from its essence. The role of the Journalist allows you to ask questions and be curious about all aspects of interactions in client contexts. When

tension rises, you can model the Mediator role and thereby demonstrate that differences can be discussed and negotiated with safety.

The Techniques: The Angel could employ a variety of therapeutic techniques or tasks within a session or as homework assignments to also deconstruct the impasse. Counter-systemic tasks could be used to directly expose homeostasis within the system. System-restructuring tasks would create structural changes in clients' cognitions, emotions, and behaviors and provide practice opportunities for new ways of interacting within the family. In order to enhance the positive elements of the Angel role, the therapist will be required to (a) track, (b) accommodate members, (c) interject hope, (d) disassemble the client's organizational structure by highlighting individual differences, (e) help family members become cognizant of their nonverbal communications, and (f) develop implicit conflict in the therapeutic session. The use of circular questioning can assist the Angel in lessening the conflict by encouraging others to help each person in the therapeutic system to think about the presenting issue from another person's perspective and to place it in an interactional context.

The Shake-UP of the Case Scenario: In the case scenario, the Angel therapist had become aware that an impasse had developed and opted for an outside consultation. The consultant agreed to attend the next therapeutic session, after client permission was obtained. By engaging in this process, the consultant became aware of verbal and nonverbal signs of conflict between the parents. The consultant turned to Bobbie and said, "Do you ever notice your parents arguing and are you worried about them?"

Bobbie began to cry and slowly described his feelings. He shared that he had been spying on his parents without their knowledge. At night, when he was supposed to be sleeping, he reported that he listened outside his parents' bedroom door. He reported hearing them arguing and being very angry at each other. Bobbie then shared, "I think it is because of me that they fight." Bobbie also revealed that when his parents leave for work and he is home from school due to a stomachache, he goes through his parents' belongings, desperately seeking an answer to their troubles. Over time, each piece of "evidence"—letters, clothing, books, even dinner dishes in the bedroom—had fed Bobbie's imagination and convinced him of his worst fear; that he had become an unbearable burden in the family. He imagined that plans were being made to separate him from the twins.

The consultant then asked the parents if they were aware that Bobbie was listening to their "secret" arguments. The parents shared that they had tried to hide their fighting from the children and they thought Bobbie was in his bed sleeping. The therapist then asked them in front of the children about their conflicts. Hesitantly,

the parents begin to discuss their differences. They also reassured Bobbie that their "fighting" was not his fault and that they loved him very much.

At this point the consultant advised the Angel therapist to have a session alone with the parents. Using humor, he encouraged the Angel to promote frank discussions of parental differences and to intensify tensions in the safety of the therapeutic environment. The Angel needed to learn more about the basis of his parents' conflict in order to understand the hidden dynamics of Bobbie's somatic complaints and to create interventions designed to resolve problems for all members of the family system. So the Angel must now take the risk of leaving his "comfortable" professional therapeutic role and select a role (i.e., the Mediator, the Detective, the Journalist, the Archaeologist) that will permit deeper investigations of parental conflicts.

In retrospect, beneath the surface of hopeful therapy sessions, Bobbie's parents refused to recognize the ill effects of deep-seated conflict in their relationship. They were constantly fighting, and the father was threatening to leave the family. Both parents thought that they were being discreet because they reserved arguing until after the children went to bed. They were unaware that Bobbie was not sleeping and was, in fact, listening to every word outside their bedroom door. Bobbie's stomachaches were a symptom of the stress he experienced because of the discontent in his parent's relationship.

The Reflection: In order to determine if the Angel is your preferred professional therapeutic role it will be helpful to utilize a variety of techniques and approaches designed to increase self-awareness:

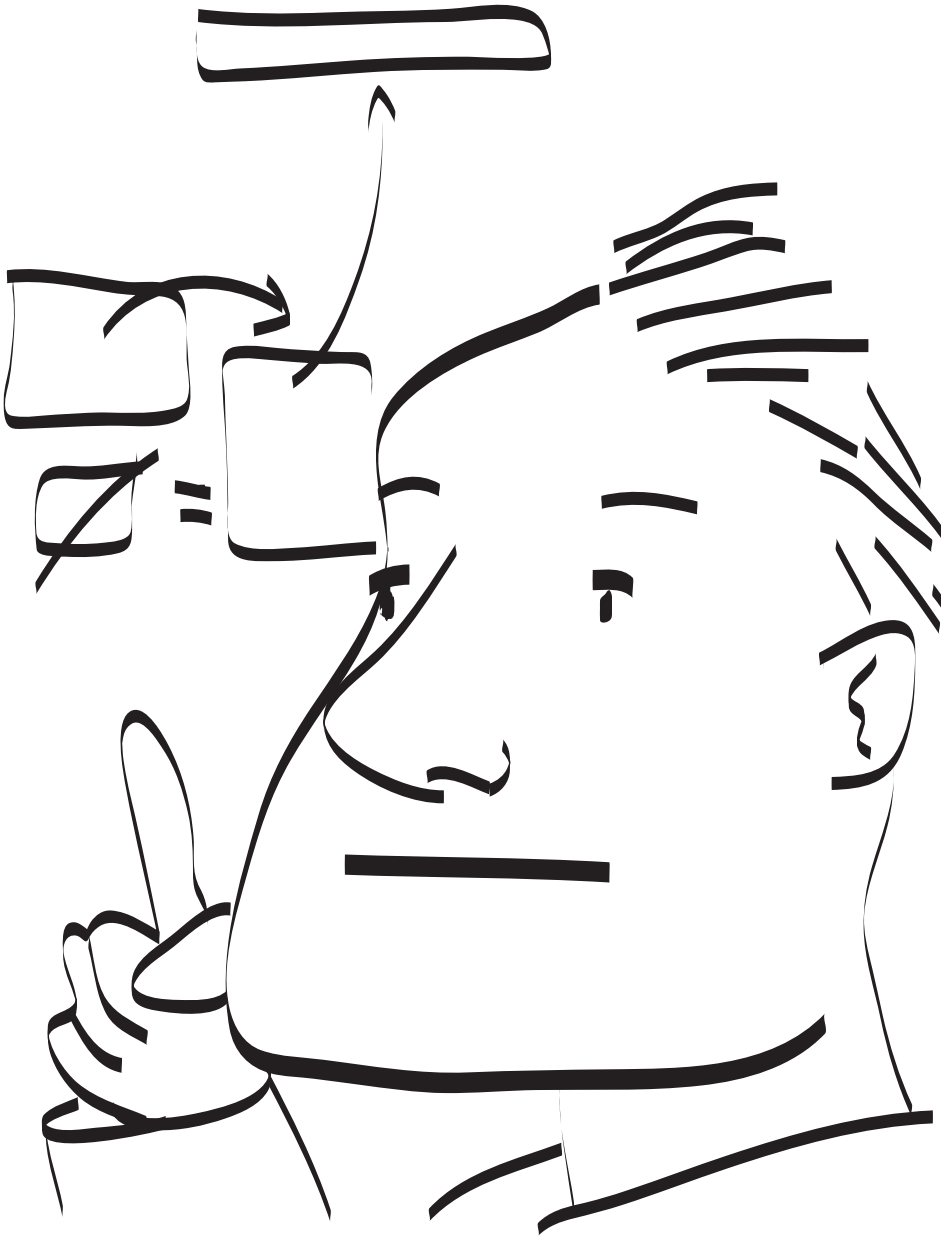
Family Genogram: Was I the interjector of hope into my family system? Did I reinterpret tense family situations into hopeful scenarios?

Social Circles: When friends fought, was I the person that they sought out to relieve their inner turmoil? If I was actively engaged in social clubs, was I the person trying to allay others' social fears by rephrasing language, watching other's actions and immediately translating nonverbal cues into more palatable interpretations?

School Experience: As a student, did I exhibit happiness regardless of the assigned task? If other students complained, would I offer them comfort regarding the work ahead?

Therapeutic Style: Am I uncomfortable with the necessary conflict and tension that arise in session? Or do I want to quickly want to develop resolution among clients? Do I often find myself saying internally "Redirect! Redirect! " when tensions arise rather than allowing the conflict and tension to direct me?

The Archaeologist



"You mentioned that your mother was one of three children. Let's go back a generation and talk about her family. Tell me about her father." The Archaeologist assumes a role of wanting to get to the root of the problem by examining the client's heritage in order to learn about how past experiences may influence presenting concerns. The Archaeologist pursues this goal by minutely examining aspects of the client's history that have significance for him. This examination may require the use of creative approaches and techniques that include a family genogram, enactment of role plays, the use of pictures in the session, sending each partner "back" to talk to their family of origin, bringing in extended family members into the session, utilizing internet capabilities (e.g. Skype) to involve remote family members in the session through telephone or videoconferencing.

Through this process the Archaeologist can address a wide range of systemic problems that may include emotional cutoffs and enmeshed and/or disengaged behaviors. The Archaeologist provides a meaningful therapeutic experience for clients by exploring family of origin issues that shed light on current personal or systemic problems.

Throughout the therapy process, the Archaeologist engages the family in a variety of techniques or tasks within and outside of the session to assist them in uncovering how the "presenting symptom" developed. Clients learn about their own interaction system, the roles that each member of the family assumes around the symptom, how extended family members help to maintain the issue and, most importantly, helps members to reconnect to extended parts of their own "living culture". Information regarding family of origin is an integral part of therapy. The Archaeologist focuses on the here-and-now while integrating the influence of past experiences by analyzing the client's current culture, immigration history, values, belief system, family rules, gender roles, medical concerns, and mental health symptoms. The Archaeologist works to uncover symptoms that have been carried from one generation to the next, which may include alcoholism, family sexual, physical or verbal abuse, depression, etc. The Archaeologist and members in the therapeutic system work collaboratively to reveal vital generational information then determine and implement solutions that result in limiting the clients interactional and communication system.

The Archaeologist's primary unspoken message to the clients is that they carry within them a family history that has influenced every aspect of their current values, beliefs, traditions, cultural connections and behavior ("living culture"). This history

has the power to help the clients resolve their own issues. The therapist assumes an active role in the session by asking questions, guiding clients to deeper levels of self-analysis and self-revelation, analyzing finds by grouping, identifying and classifying them and then teaching clients how these finds are influencing them and contributing to the present concern. The Archaeologist demonstrates skill at balancing what the client shares through narratives while not allowing him to self- disclose to a point of becoming emotionally overwhelmed. The Archaeologist is comfortable in allowing tensions to develop within a session and is able to remain cool under the stress that such tensions create. As appropriate, the Archaeologist will work to reduce tension through the use of questioning about past client experiences and relating them to current concerns.

The Archaeologist gathers each family member's perspectives about the family history by allowing each member to have a voice in the session. Archaeologists demonstrate effective interpersonal and rapport-building skills with a wide range of clients. They express genuine interest in clients, efficiently analyze client information, and share observations in a timely manner. The Archaeologist works with all clients in the family system to reveal and explore important historical information from multiple perspectives. This process enables the therapist to teach clients how historical family dynamics can create and maintain current dysfunctional behaviors. It further enables the Archaeologist and clients to collaboratively develop and implement therapeutic interventions that hold the promise of lasting change for clients.

The Positive Use of the Role: The professional therapeutic role of the Archaeologist is positively enacted in sessions with a wide range of presenting problems. By asking questions and studying family artifacts, the Archaeologist creates a safe emotional environment in the session where clients are free to talk openly, teach others about their history and share their perceptions of past events. This therapeutic climate promotes a sense of hope, calmness, and peace between and among clients. Different viewpoints are allowed and encouraged when communicated with respect. When successful, such communications create opportunities for clients to relate on more genuine and accurate levels. The Archaeologist helps clients to examine both their family history (positive and negative) as well as their relationship history and then connect these histories to extant problems. The Archaeologist models for others how to be curious, inquisitive, and open to information that is presented. The Archaeologist remains poised when tensions arise and clients leave sessions with a sense that no matter how serious their situation may be, there is hope and a sense that they have grown to know each other at a deeper level. The Archaeologist, like the Journalist and the Detective, is skillful in asking questions that lead to the discovery

of hidden conflicts, which underlie presenting symptoms. Because the Archaeologist demonstrates inquisitiveness, curiosity, and intrepidness in asking difficult questions about the past, he is able to win client confidence and trust.

The Seduction: Impasse Contributing: The Archaeologist role is seduced into action when clients come to therapy looking for someone who is interested in their family history or who would rather conduct a family search or discuss a family artifact rather than focus on therapeutic change. By focusing on a client's desire to discuss superficial aspects of family history, the therapist and family are unable to connect clinically important aspects of historical dynamics to the presenting problem, thereby limiting therapeutic effectiveness. For example, the therapist may assist clients to identify resources that may reveal information about family history. However, the Archaeologist becomes seduced in the search and spends the session exploring resources rather than historical family dynamics, which contribute to an impasse.

The Impasse: Through an exploration of historical family dynamics, the Archaeologist works to illuminate conflicts with the goal of revealing the underlying causes of presenting symptoms. Most clients will respond well to the investigative nature of the Archaeologist. However, when clients are not interested in Archeology digs, an ongoing search for historical details may result in client irritation and a shut down in communication. As discussion related to current events is limited, clients and the therapist become stuck. Initially, clients may demonstrate interest in learning about their family heritage. However, this less than productive process may motivate clients to focus more on presenting concerns. When the Archaeologist encourages clients to focus exclusively on exploring family history and artifacts, client disenchantment and premature termination may result.

The Case Scenario: Frank and Jenna were referred for couples counseling by personnel at a women's abuse shelter because of reported spousal abuse. During the initial session, the husband took the initiative to talk. Jenna, who had a noticeable bruise on her face, sat quietly with hands folded in her lap. The husband shared with the counselor that there was really no reason to be in therapy and that everything was a misunderstanding. At that point, Jenna looked out the window and began to fidget in her chair. The Archaeologist assured the husband that there may have been misunderstandings, but that he was glad the couple was there to learn more about their family histories and how their family background could be causing some differences between them. Frank immediately began to share about his family and said that Jenna's family was not worth wasting his time to discuss. Jenna began to weep. The Archaeologist began to ask questions about Frank's father, "Share with me about your

father…did he work?" "Is he still alive? " "How many siblings do you have?" "What do you know about your father's childhood?" As Frank spoke, the Archaeologist began to draw a family genogram. The Archaeologist then focused the session on Frank's father and Jenna spoke very little. The therapist suggested that Frank should call his father between sessions to determine what additional information he could learn about his father's childhood and bring his findings to the next session. Issues related to spousal abuse or the bruise on Jenna's face were not addressed.

Upon leaving the session, Frank seemed quite pleased and said they both he and Jenna would return. Jenna did not comment or say a word to the Archaeologist. The next day, the social worker from the agency phoned and said that Jenna had been badly beaten by her husband and was in the emergency room of a local hospital. The social worker revealed her dismay with the Archaeologist as Jenna had informed her that no information about her husband's abusive behavior was gathered and she did not feel protected or heard in the session. The social worker informed the Archaeologist that she was referring the couple to another therapist.

The Risk: In order to move out of the therapeutic role of the Archaeologist, the therapist must address presenting issues directly and objectively. This is particularly important in cases of reported abuse because of ethical and legal mandates to insure client safety. The Archaeologist must work to establish client rapport, therapeutic trust, and a psychologically safe environment while asking questions related to reported abuse. The Archaeologist may need to quickly act on minimal information and develop immediate interventions to insure client safety. These are extremely risky behaviors for the Archaeologist, who is more comfortable asking questions, being curious, drawing family genograms, and relying on client reports to determine problems. The Archaeologist must temporarily suspend curiosity and adopt a more disciplined approach to insure client welfare. By creating an atmosphere of safety and trust that allows clients to explore conflicts, the Archaeologist promotes interactions and tensions around a symptom to surface and be discussed.

The Alternative Intervention Style-Impasse Busting: There are a number of therapeutic professional roles that the Archaeologist can utilize to explode a face-to-face impasse with clients who are resistant to talk. The role of the Bird Watcher permits the therapist to join the family system by adopting a disengaged stance and gathering relational information around the symptom via nonverbal communication. This information can be used to analyze areas of discontent and stress in and among clients and may be helpful in restructuring the client's organization. The professional role of the Clown may be useful when tensions are high and levity may provide relief. Also the use of this role can create a total different view on the relations or problem

and change the interactional patterns. The roles of the Angel and the Savior may be adopted when a need exists to demonstrate a desire to help, understand, and create an atmosphere of safety. The Archaeologist may even need to adopt the Firefighter role in extreme cases to insure client safety within and following the session. This professional therapeutic role would help the Archaeologist attend to the immediate crisis at hand before trying to investigate the history of family members. The role of Construction worker may also be useful in creating an environment where all family members present can be heard.

The Techniques: The Archaeologist can employ a variety of therapeutic techniques or tasks within a session or utilize homework assignments to deconstruct the impasse. The technique of circular questioning would assist family members in listening to the views of others. The Archaeologist must focus on tracking and accommodating clients' conversations without quickly formulating additional questions. Rather than just asking questions, the Archaeologist can employ a variety of structural tasks that could involve countersystemic, contextual, displacing, system-restructuring, and reinforcing tasks. All of these tasks would allow the Archaeologist to focus on the client's immediate distress rather than promoting conversation. Further, he can take a less neutral stance and redefine the problem or relations. In addition, the Archaeologist could add or subtract systems, focus on the symptom itself or modify the organization of the clients in order to create a physically and psychologically safe environment.

The Shake-UP of the Case Scenario: In the case scenario presented, the couple had been sent to another therapist in the same agency. The therapist had spoken to the Archaeologist prior to seeing the couple and was aware of the reported abusive treatment of Jenna by the husband. The therapist decided that he would begin the session by being a Bird Watcher. He immediately noticed that Frank dominated the session and whenever Jenna tried to speak, he minimized her input and cut her off. The Bird Watcher also noticed that when Jenna spoke, Frank clenched his hands into fists and he appeared to be highly agitated. Jenna's body began to shake and she stared at the floor. The therapist then moved into the professional therapeutic role of Construction Worker by directing Frank when to speak or remain silent, thereby affording Jenna opportunities to express herself. As Jenna spoke, Frank's agitation increased and he glared at her. Consequently, she became silent. As the Construction worker became aware of Frank's agitation and Jenna's withdrawn behavior, he shifted into the therapeutic professional role of the Savior. At this point, he asked Frank to leave the room in order to speak privately with Jenna. Reluctantly, Frank complied.

Jenna said that she was afraid of Frank. She reported that he had recently lost his job and was drinking heavily. Jenna reported that Frank's anger was initially displayed through verbal abuse, but that he had recently struck her and that his physical abuse was becoming a nightly occurrence. Jenna stated that she had initially been able to hide her cuts and bruises, but that Frank recently began hitting her in the face and about her head. Jenna said that she had no place to go and was certain that, if she remained in the home, he would accidently kill her. The Savior told Jenna that her safety was of utmost importance and that because Frank's abusive behavior was now a nightly pattern, she would not be able to go home with him. With her permission, the Savior contacted a local women's abuse shelter and made arrangements for her to be transported immediately.

The Savior then spoke to Frank alone and shared his concerns. At first, Frank was verbally hostile. However, as the Savior discussed Jenna's visual signs of abuse, Frank calmed. The Savior also plainly informed Frank that physical abuse is a criminal act that could lead to a court conviction and imprisonment if Frank did not cease and desist. The Savior indicated that Jenna would remain at the Women's shelter until an assessment was completed and professionals determined that it was safe for her to go home. The Savior spoke to Frank about his need for referral to a substance abuse program and an assessment to help him find employment. The prospect that an assessment might help him become employed again calmed Frank and he readily agreed to all conditions.

In retrospect, Jenna was in serious physical danger. The Archaeologist failed to address the immediate danger and an impasse developed. Through the professional therapeutic roles of Bird Watcher, Construction worker, and Savior interventions were developed that immediately protected Jenna and gave hope to Frank that his current problems with abuse, substance abuse, and unemployment were amenable to change.

The Reflection: In order to determine if the Archaeologist is your preferred role in a therapeutic environment, it would be helpful to examine:

Family Genogram: Were you the one in the family that was constantly trying to learn about your family's heritage? Did you try to create a family histogram?

Social Circles: With friends, were you constantly asking questions about their family members in order to try and help them? Did you suggest that meeting notes from previous years might help with decision making?

School Experience: As student, were you the one in the classroom who would you quickly analyze situations, ask questions and then offer to write a story from a historical perspective?

Therapeutic Style: Are you constantly asking questions and probing for more information from clients regarding their family backgrounds? Do you often create family genograms? Do you advise your clients to call a family member to gather more information about a particular person? Do you often find yourself saying, "I wonder about your childhood experiences"? When tensions rise, do you typically request historical family information from clients?

The Bird Watcher

Barely a sound is uttered, but the Bird Watcher's eyes are widely open and intently focused on the client, watching every move, every sigh, and every action. Periodically, a sound of encouragement is uttered by the Bird Watcher, allowing the client to continue discussions and to let the clients know the therapist is present. Through minimal utterances and brief comments, the Bird Watcher acknowledges and encourages the client's communication and interactions, but shares little. The focus of therapy is to listen to the presenting information and note all nonverbal communication within and between the members in the therapeutic session. The Bird Watcher is often inactive in the session and clients initiate all discussions. As soon as the session is over, the Bird Watcher leaves the session and creates copious therapeutic notes about the session and the nonverbal interactions. The recorded progress notes are basically for the Bird Watcher's recall and rarely does the Bird Watcher share observations or gather information with the client. Rather the Bird Watcher continues to record and update information provided by the client during each successive session. The primary unspoken message to the clients is that you need to find the solution to your problem yourself; I provide the stage and you are the players. However, the subliminal message to clients is that you are in such a mess I have no idea of where to start.

The Positive Use of the Role: The role of the Bird Watcher would be very useful with a variety of client types. The Bird Watcher role is vital to employ when a client has difficulty verbalizing information, but conveys interactional communication messages via nonverbal behaviors. The Bird Watcher can register the nonverbal interactions and use the progress session notes to make hypotheses regarding the presenting symptom from personal observations. Another intentional use of the Bird Watcher role occurs when clients try to seduce the therapist into taking the lead in the session; wanting you to talk for them. In these cases it is more productive for the therapist to encourage client communications while assuming a less active and observational role in the session.

The Seduction: Impasse Contributing: The Bird Watcher role is often activated when clients enter a session and present highly complex and confusing interactional patterns. The therapist may be overwhelmed by the complexity of presenting issues and simply allow clients to engage in their highly enmeshed, family interactional dance, frequently longer than is necessary to understand family interactional

patterns. This behavioral reaction to the member's interactional dance leads to an impasse, which can manifest in a variety of ways. Clients may discuss a wealth of relevant and irrelevant topics in lively ways as if you are not present. Clients may frequently interrupt and speak for each other, while tempers flare and behaviors become more animated. If the therapist interjects a comment, clients may ignore him and proceed with their typical form of communication.

Impasse: The Bird Watcher encourages communication, but rarely does more than collect and document it. Some communications may be directed toward the therapist, who listens but says nothing more than a few words. The therapist does not use the shared information to enhance couple or family communication. Thus, clients frequently fail to learn about their current or new interactional styles, their family structure or organization, and the presenting symptom often becomes a more entrenched dynamic within the therapeutic system. The therapist uses information about problem development only for recording purposes. In the therapeutic milieu created by the Bird Watcher, family interactional patterns do not change and may become more dysfunctional. As a result, therapy may end prematurely as the individual, couple, or family become frustrated because little or no change to clients' interactional style has occurred (nor is change likely to occur in this therapeutic climate). Clients frequently describe their therapeutic experiences with the Bird Watcher as "useless."

The Case Scenario: A family of six persons, father, mother, sons ages 31 and 29, daughters ages 24 and 22, enters treatment at a community mental health center and meets with a young female therapist who is being supervised from behind a one-way mirror. The 31-year-old son is dressed in a long caftan, wears a red strap around his long hair, and holds a 6-foot long wooden stick in his hand, although he is not handicapped. The younger son looks angry. The father begins by talking about the difficult behavior of the eldest son, who immediately interrupts his father to tell a story that is irrelevant to what the father is saying. The mother interrupts the son, but nobody listens to her. The eldest daughter attempts to speak to the therapist, who is overwhelmed by the blitzkrieg of unrelated conversations directed at her. Not only does the therapist fail to hear and understand these communications, but also fails to promote effective communication among family members. The therapist is further dismayed by the nonverbal behavior of the eldest son, who taps the floor vehemently with his huge stick. The therapist sits back and says nothing to the family. This pandemonium lasts for 15 minutes; finally the father states in total frustration, "This therapy is going no where".

The Risk: A fundamental learning goal for the Bird Watcher is to take an active role in the session. The Bird Watcher must allow normal family interactional patterns to emerge in the session as he also actively works to alter interactional patterns through the use of metaphorical or paradoxical tasks. The Bird Watcher must assume executive responsibilities for controlling the session by directing communications among family members in order to teach productive communication skills. Perhaps the greatest risk for the Bird Watcher is to use new techniques when he is unsure of how to respond, of how clients may respond to his directives, or when he feels overwhelmed by a deluge of dysfunctional communications. In such circumstances the Bird Watcher must muster the courage to act in the face of uncertainty.

The Alternative Intervention Style-Impasse Busting: There is a number of therapeutic professional roles that the Bird Watchers can utilize to deconstruct a face-to-face impasse with a client. The role of the Referee would be useful to control family interactions and stop family members from interrupting each other. When face-to-face with a highly enmeshed system, assuming the role of the Mediator could teach the family negotiation skills and enhance their ability to listen. These new skills can then be practiced to negotiate productive solutions to problems. The role of the Teacher enables the therapist to assume a more respected position in the therapeutic system. Through discussion, role playing, and/ or changing sitting positions, family members can learn to modify rigid coalitions to create more adaptable and respectful roles and communication patterns. Adopting the role of the Detective enables the therapist to take an active therapeutic role by asking clients about details of family life that requires each family member to engage in focused dialogue. Assuming the roles of the Journalist or the Archaeologist can create a more structured approach to gather client and family information in a more systematic manner. These roles also provide opportunities for the therapist to demonstrate high levels of psychological presence and interpersonal engagement with the members of the therapeutic system. A note of caution is offered when considering the role of the Secretary, which is similar to the Bird Watcher role in relation to note recording. As noted earlier, clients may interpret note-taking behavior as a demonstration of therapist aloofness and disinterest.

The Techniques: The Bird Watcher may employ a variety of therapeutic techniques or tasks within a session or as homework assignments to deconstruct an impasse. These include: (a) the development of a family genogram with clients during regular sessions; (b) use of a talking stick that is passed from client to client during sessions in order to determine who speaks; (c) interjecting therapist feedback to alter a family's enmeshed interactional style; (d) system restructuring tasks that utilize elements

in the session to restructure interactional patterns; and, (e) metaphorical tasks to deconstruct rigidified systems. Regardless of the technique used, it is imperative that the Bird Watcher adopts an *active* role to block unproductive transactional patterns within the therapeutic session. As illustrated in the case scenario, the use of metaphorical and provocative actions may be required to break out of a preferred role. These techniques can be implemented more effectively when the therapist is working collaboratively with a team of co-therapists, of whom at least one is serving as a supervisor behind a one-way mirror during therapy sessions. The supervisor is in a unique position to objectively evaluate therapist performance in various therapeutic roles and provide feedback to enhance facility in each role.

The Shake-UP of the Case Scenario: As illustrated in the case scenario, the beginning therapist had been seduced into the role of Bird Watcher. The supervisor behind the one-way mirror asked the therapist to leave the therapeutic room for a discussion. Privately, he asked her if she was courageous enough to change her role, and if so, was she willing to do what he suggested. The therapist readily agreed to comply with the supervisor's request because she felt overwhelmed and uncertain of how to proceed in the session. The supervisor then asked her to return to the session and to lie down on the floor in the middle of the room. While lying prone, the supervisor directed the therapist to close her eyes and listen very carefully to all family communications. He further directed her to remain in this position until he would call her by telephone.

The Bird Watcher does as she is asked and lies down on her back in the center of the room with eyes closed. The family members stop talking and look at the therapist. After two minutes of silence, the son with the stick asks his father: "What is she doing? The father answers him and says, "Perhaps she is ill?" "I do not think so" the mother said. Very concerned, the family discussed the therapist's condition for ten minutes. All members listened to each other; family communications were clear, direct, and orderly. After ten minutes (later the therapist reported to the therapeutic team that it seemed like ten hours), the supervisor phoned. The therapist answered the phone and the supervisor asked her to speak with the members of the family about their experience as she lay on the floor. Following the family discussion with the supervisor, the session proceeded very differently. A theme emerged in the session that was characterized by family members listening carefully to one another and providing time for each person to think before speaking. The son placed his stick in the corner and the meaning of the stick became a topic of discussion. As the family engaged in respectful communications, it became evident that the diversity of ideas generated by family members was a source of conflict that underscored a

larger problem of role differentiation. The therapist scheduled the next session with the goal of exploring these issues in greater depth.

Following the session, the supervisor praised the therapist for her enormous courage and discussed with the therapist how it felt to fully enlarge her role of non-intervening Bird Watcher. The therapist shared how difficult it was and how she longed for the moment where she could be present in a more active way. They discussed how the use of this technique may have prompted changes in family roles that led to more functional communication patterns in the remainder of the session. In retrospect, despite the impasse created by adopting the Bird Watcher role, enlarging the role and making it more dominant in the session required family members to alter their communication dynamics in productive ways. Awareness of their ability to make necessary shifts in communication dynamics instilled a sense of hope in all family members that resulted in an ongoing commitment to the therapeutic process.

The Reflection: In order to determine if the Bird Watcher is your preferred role in a therapeutic environment, it would be helpful examine:

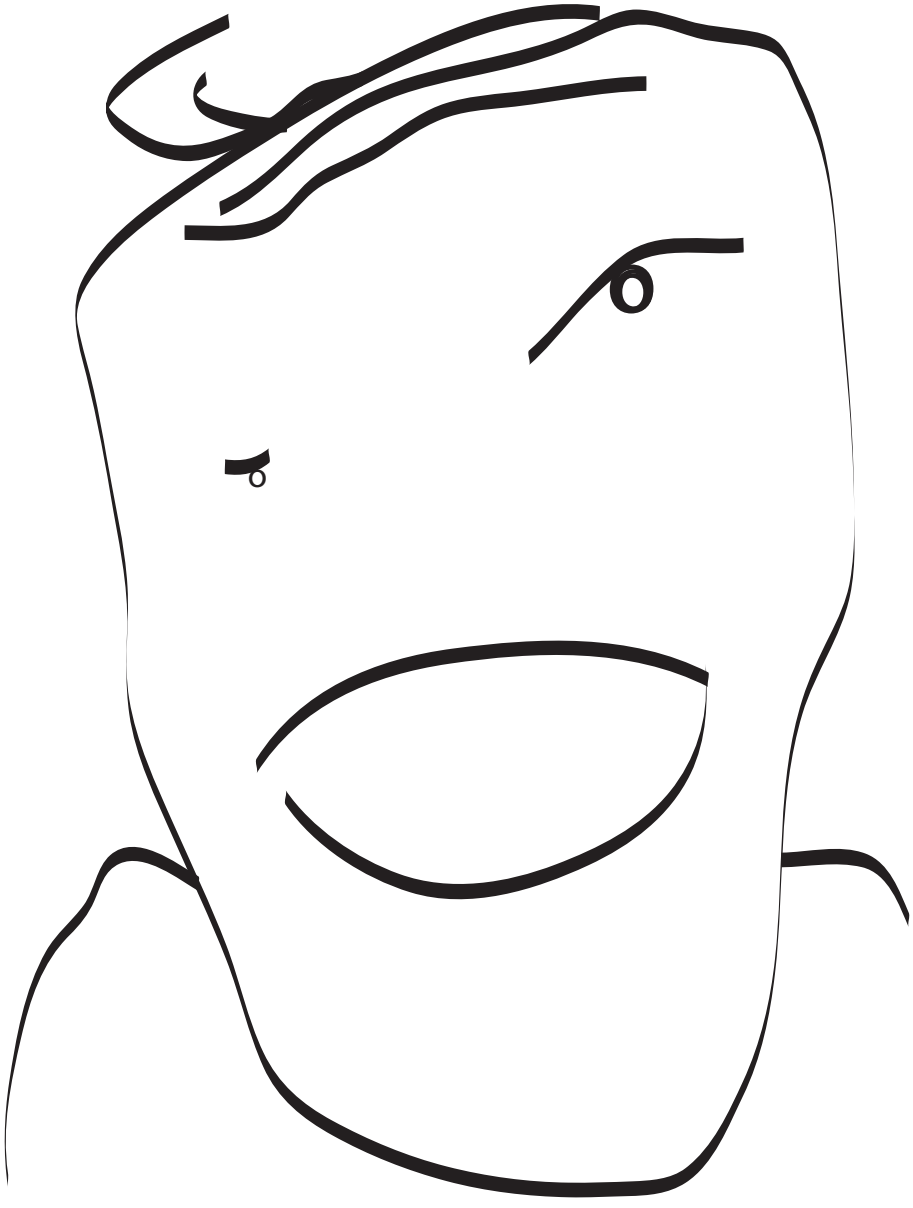
Family Genogram: When family conflict developed, did I become quiet, sit back, and observe family members in action?

Social Circles: When friends argued or when tensions rose in personal relationships, did I pull back, watch, and not say a word? If I was actively engaged in social clubs, was I the person who would sit back and observe other members and not say word about the process?

School Experience: As student, was I the one who observed class members but did not a say a word?

Therapeutic Style: When client conflict or tension arises in the session, do I find myself sitting back, observing and not responding to the interactions? Do I avoid allowing the conflict and tension to direct my work?

The Clown



Chapter 8

Of all the professional therapeutic roles assumed by a therapist, the role of Clown can be one of the most profound and yet at the same time, confusing to clients. In this professional therapeutic role, the therapist interjects humor, laughter, creativity, or playfulness into the session in order to create levity when a negative atmosphere is sustained by conflict or escalating tensions between family members. In such circumstances, the Clown may tell jokes, offer humorous comments, or even make exaggerated faces in order to relieve tension. The Clown often uses humor and creativity to re-define the presenting problems and reframe the concerns into positive connotations that can surprise the clients. Humor allows the Clown to address very painful and avoided problems in a humorous way that helps the client's look at the presenting concerns in a more manageable way.

Clowns have a good sense of timing and balance and are able to monitor conflict levels in sessions. Clowns are creative, witty, and are able to improvise quickly when necessary. Their strongest quality is that they are able to re-define the presented problems and behaviors in a humorous way that makes it possible for all members of the therapeutic system to look at their behavior, prejudices, and world views from another perspective. Based on client needs, the Clown must change his humoristic style in response to unique client reactions. Through this professional therapeutic role, the therapist assumes the responsibility for the affect in the session. As a result, the Clown works very hard and is highly active in sessions to insure that even intense conflict is addressed in a productive way. The primary unspoken message to the family is that whatever your situation may be, I will help you to see things from a different, less serious, perspective and show you that there is hope as long as you are willing to look at your problems differently and be courageous enough to stop the rigid behavioral patterns. Humor will create flexiblility that will help clients see their problem from a different perspective. When used as a rigid preferred professional therapeutic role, the therapist may use humor to compensate for feeling lost, insecure or inadequate in a therapeutic situation or to avoid tension that is necessary for change.

The Positive Use of the Role: This professional therapeutic role can be quite useful with many clients in specific circumstances. The professional therapeutic role of the Clown is positively enacted with clients who are very rigid, authoritarian-like, or who may take an overly serious perspective on a given issue. Simply stated, the Clown helps clients to look at themselves through a different and less serious lens.

By creating a lighter and very different emotional atmosphere, family members may gain new insights into their relationship dynamics and begin to relate to each other on a different interactional level. By helping to break down rigid family structures, the Clown creates opportunities for clients to enhance individual, marital and family interactions. The Clown is also able to look at his own role in the therapeutic system with humor and relativism and can even exaggerate the expectations that the family has towards him. For example, one time a family looked at the Clown therapist and asked him to make some decisions for them as they had three options and could not agree. The Clown therapist picked up some dice and said, "The first throw would be for the first choice, the second throw for the second choice and third throw for the third choice". The family looked at the Clown therapist half surprised and half angry. After some silence they asked, "Why would you handle our dilemma like this?" The Clown replied, "I would never be able to get enough information from you to make a responsible choice so throwing the dice was my best option. The family looked at the Clown therapist as if they saw water burning. Then they laughed and said, "You are right, we have to solve this ourselves". The Clown is a very useful professional therapeutic role that, when used with balance and precision, can yield both immediate relief in the therapeutic milieu and lasting changes in system dynamics.

The Seduction: Impasse Contributing: The Clown is seduced into action by clients who come to therapy with significant levels of pain or depression and who actively seek out someone to relieve their pain. Clients' presenting affects and concerns are often highly emotionally charged and the session atmosphere quickly becomes somber and tense. Like a hero, the Clown is there to intervene with humor in order to reduce this tension. The Clown is seduced into covering up clients' pain by interjecting unwanted humor and this contributes to an impasse. When the Clown uses humor inappropriately, there is a risk of not being taken seriously and clients may quickly lose respect for the therapist. Stephen Sondheim's lyrics (1993) *Send in the Clowns* aptly captures inappropriate "Clown humor" when he writes, "Isn't it rich? Are we a pair? Me here at last on the ground, You in mid-air. **Send** in the **Clowns."** These lyrics symbolize the pain that emerges in an estranged relationship when one person decides to leave after a prolonged experience with conflicted feelings. Sondheim's lyrics highlight the cynicism such a situation evokes. Because the couple's relationship has mirrored the ups and downs of a circus, they sarcastically ask for the Clowns to interject humor. In the therapeutic milieu, such humor would not only be inappropriate but would also likely serve to irritate clients.

The Impasse: Feeling pressured to protect clients from emotional pain the Clown tries to make the members in the session laugh instead of provoking them in a

humorous way to look at their behavior and problems from a different perspective. This allows the members within the therapeutic session to look at their behaviors and problems form a different perspective. He consistently acts to interject humor when underlying symptoms for client problems are discussed. Consequently, family members are prevented from authentically exploring problems and relationship dynamics that brought them to therapy. Through haste and wanting to "save" clients from pain, the Clown creates a focus on levity rather than genuine client concerns, which insures that the therapeutic process will be less than productive.
Although everybody seems to be laughing (especially the Clown therapist), change cannot occur. Clients and the Clown therapist become stuck because the root of the problem is neither allowed to surface nor explored in depth. Often, clients feel as if their situation is not taken seriously, and they become angry or simply do not make another appointment.

The Case Scenario: Emily, a mother of four, is experiencing severe depression. Her husband feels completely helpless and contacts a therapist. The couple and their children attend sessions, during which Emily weeps and says very little. Feeling the weight of his wife's depression, her husband sighs regularly while the children demonstrate inappropriate behaviors and ignore their parents' requests. This dysfunctional communication pattern plays out with the husband yelling at his wife.
Jokingly, the Clown says that he would cry also if he had to deal everyday with the children. Family members glare in astonishment at this response. The Clown attempts to recover by interjecting more humor by saying, "Oh my! You look like you all saw a ghost, and let's call him Jimmy." The husband attempts to redirect the session by commenting on the seriousness of Emily's depression. Each time the subject is broached, the Clown responds with jokes, laughter and humorous comments. After several sessions, little information about Emily's condition is revealed and she appears to be even more depressed. Feeling disgusted with the therapist's behaviors and concern for his wife's deteriorating condition, the husband calls the therapist to inform him that the family will not be returning for additional sessions.

The Risk: In order to move out of the professional therapeutic role of the Clown, you must listen carefully to client concerns with concern and compassion. This is extremely risky for the Clown, who is used to interjecting humor when tension builds or using humor to create different perspectives as the good functioning Clown therapist does. The Clown must demonstrate comfort with and openness to expressions of conflict that emerge in sessions so that behavior patterns around the presenting concern can be identified at both verbal and nonverbal levels. Expressions of conflict and resulting tensions are especially difficult for the Clown who desires

an atmosphere that is light and tension free. The Clown may freeze and not know how to respond to clients who present anger, pain, grief, sadness, or depression. If the Clown demonstrates inabilities to self-correct, he may benefit from live supervision by a professional consultant (i.e., use of a one-way mirror). The consultant would encourage the Clown to deal with the present moment, engage in new intervention and therapeutic approaches, and utilize strategies to prevent the Clown from relapsing into his preferred professional therapeutic role. Therapists must recognize that conflicts and tension within the session are not only inevitable, but also can be productive in promoting client change. Without this stimulus for change provided by conflict, homeostatic system dynamics will remain unchanged.

Despite the potential limitations of misuse and overuse described above, the role of the Clown may be productively used in the therapeutic process. At issue is the ability to productively balance and use humor to touch in a very sensitive ways the very painful areas within the clients. The Clown should not use humor to avoid tension but rather use humor to manage, control, and confront tensions so that clients are able to gain a new perspective on their presenting issues. The Clown needs to learn how to balance this professional therapeutic role with other professional therapeutic roles so that the expertise of the therapist is not undermined by efforts to minimize session conflicts.

The Alternative Intervention Style-Impasse Busting: There is a number of professional therapeutic roles that the Clown can utilize to deconstruct a face-to-face impasse. Adopting the role of the Teacher creates opportunities to guide and educate the family into action and change. Operating in this role also lends a sense of sincerity and care as the therapist responds to client concerns by identifying potential strategies to resolve problems. Adopting the role of the Savior, in concert with the role of the Angel, enables the therapist to communicate hope, promote knowledge, and create a sense of safety while allowing family members to take responsibility for change. Therapists operating in the Mediator role would teach family members to communicate clearly and assertively, thereby creating more functional interactional patterns. Adoption of these combined roles may help to reduce the sense of helplessness inherent in many dysfunctional family systems. Working in an integrated role of the Detective, the Archaeologist and the Journalist provides opportunities to demonstrate genuine interest and concern in the underlying issues and problematic behaviors demonstrated by family members. This process may be highly effective in freeing clients from "needing" the presenting problem. The role of the Bird Watcher may also be useful in providing opportunities to observe the non-verbal behaviors between members in the session when tensions arise.

The Techniques: The Clown may employ a variety of therapeutic techniques or tasks within a session or as homework assignments to deconstruct the impasse. When working with clients who present with very strong affect (e.g., depression) the therapist may need to reposition the family by adding or subtracting members in the therapeutic system. The therapist may need to shift the focus on the presenting symptom by overly exaggerating, relabeling, or de-emphasizing the symptom. Altering the affect around the symptom may reduce clients' emotional reactions and help to relieve anxiety. When a change in the session atmosphere is indicated, the therapist may employ contextual tasks. Displacing tasks could help to shift the symptom from one family member to another and create greater flexibility in abnormally rigid relational patterns. Circular questioning may be useful when one family member is unable or unwilling to speak. This technique may also be used to illuminate specific relationships in the family system. Reorganizing the system's interactional behaviors around the symptom may help to change the homeostatic patterns that are embedded in and around the symptom. The use of counter systemic tasks may be used to challenge homeostatic family patterns, while paradoxical tasks, which prescribe the symptom or rules to be further enacted and carefully employed, could be used to implode the idiosyncratic rules and behaviors present in the therapeutic system. The paradoxical technique of prescribing the symptom may help to determine if the symptom is under the control of the IP. The therapist may also "attack the symptom" with the goal of helping family members to perceive the symptom as ridiculous.

The Shake-UP of the Case Scenario: In the case scenario presented above, the Clown requested one more session before the father terminated the therapeutic relationship. The father reluctantly agreed. Before the final session, the Clown contacted a colleague and asked for a consultation. The colleague asked the Clown many questions about the family's history such as when the mother's depression surfaced, the father's responses to acting out behaviors by the children, and members of the family in caregiving roles, among many others. The Clown was unable to answer any of the questions. The colleague noticed that as more questions were asked, the Clown became noticeably uncomfortable and began to "crack" jokes about his lack of perception in the case. The colleague shared his concerns and observation about the jokes and asked if this was his style in the session. The Clown shared his perception that family members seemed to "like him better" when he made them laugh. Adopting a stern voice and demeanor, the colleague issued a directive that the Clown was prohibited from using any humor in the next session. Instead, the Clown was to adopt a Bird Watcher role and to carefully observe dynamics between

family members when circular questions about presenting concerns were used. The consultant also directed the therapist to adopt the Detective role and ask circular questions about the presenting depression of the mother.
In the next session, the Detective asked the mother whom she thought was most knowledgeable about her depression and in what way this person expressed concerns. These questions elucidated the fact that the mother's depression was draining system resources and tied the mother's depression to behaviors demonstrated by all other family members. The Detective then asked a similar question to the father and to all of the children. For the first time, the family began to speak of the depression and its impact on the entire family. At the close of the session, the father shared he was pleased that they returned for another session because he understood more about his wife's depression and the pain being created and experienced by all family members.

In retrospect, the Clown tried to lighten the seriousness around the mother's depression which may have been a correct technique to apply initially. However, an impasse developed as the Clown relied only on humor and failed to uncover the reasons for the mother's depression. Through the use of circular questioning the Clown was able to make progress with the family as for the first time the family recognized how the mother's depression was impacting the entire family.

The Reflection: In order to determine if the Clown is your preferred role in a therapeutic environment, it would be helpful to explore your:

Family Genogram: Did you often use humor to deflate or minimize tensions in your family? Were you able to help your family look at problems from a different perspective?

Social Circles: When with friends, did you work hard to make everyone laugh when conflict emerged or tension escalated? If you were actively engaged in clubs or social organizations, were you the person consistently working to make others laugh? Were you the person who could re-define relational behavior in a "Comedian" way and who could loosen tensions to make fruitful interactions possible?

School Experience: As a student, were you referred to as the class clown? Would you re-define presenting problems creating moments of silence and then a shift in thinking?

Therapeutic Style: How much humor do you interject in a session? Do your clients get annoyed when you joke? Are you able to create fruitful chaos in the system? Can you redefine roles in a playful manner so the clients feel surprised and are forced to look at you and each other from a different angle?

Construction Worker

"What? Stop? Hold It! I don't think it's a good idea to go there." The Construction Worker metaphorically lays brick after brick and pounds nail after nail to create session structure; so much structure, in fact, that no one in the session seems to remember the purpose of therapy. The Construction Worker assumes an active role in this process, which eventually serves to thwart clients' natural interactional styles and diminish therapeutic effectiveness. Due to the high levels of energy expended in the session, the Construction Worker often feels exhausted when it is over. By creating excessive structure, the Construction Worker unwittingly blocks clients' attempts to create an interactional system. In this process, the focus of therapy shifts from clients' concerns to the Construction Worker's control. The underlying reasons for the presenting symptoms are only briefly discussed as prescribed by the Construction Worker. The primary unspoken message from the Construction Worker is that clients need to limit discussion and no matter what you present, I the therapist, have a quick fix for the symptom.

The Positive Use of the Role: The professional therapeutic role of the Construction Worker is positively enacted when clients impart so much information about their family history that structure is needed for it to make sense. In chaotic sessions, family members may interrupt each other's communications, attempt to speak for each other, or a single member may speak without pause for lengthy periods to the exclusion of input by other family members. In such circumstances, the Construction Worker can intervene to block irrelevant information and structure the session with the goal of making it safe for each family member to be heard. The effective Construction Worker can encourage clients to thoughtfully examine system dynamics that maintain problematical behavior, respond in less reactive ways, and demonstrate respect for all persons in the session.

The Seduction-Impasse Contributing: The Construction Worker is seduced into action by clients who come to therapy looking for opportunities to complain about the poor communication dynamics of other family members. Members provide little information about the presenting problem and when the Construction Worker attempts to identify it, family members demand a quick fix for the symptom. Family members do not demonstrate genuine commitments to examine problems that brought them to therapy. By virtue of the dysfunctional and chaotic interactions that result, the Construction Worker is seduced into their interactional pattern.

In this process, the Construction Worker creates a therapeutic climate in which discussions about family conflicts are suppressed and unconsciously colludes with family members to avoid examinations of interactional issues. As a result, symptom dynamics remain obscured, which further contributes to the impasse. Not surprisingly, the Construction Worker too often attempts to solve the problem before exactly knowing what it is.

The Impasse: The Construction Worker severely restricts clients' communications. All conversations are directed toward the Construction Worker, who controls how much information clients impart. The Construction Worker is quick to create walls and wants to focus each session on building a quick solution to problems. Clients seem to appreciate the Construction Worker's suggestions, but never make progress because their problems have never been adequately identified, discussed or resolved. The quick solutions offered by the Construction Worker only serve as a band aide for the presenting issues. Clients and the Construction Worker become stuck as key information about the symptom becomes marginalized or avoided. Interventions are superficial and only mask the symptom, which invariably reappears. Although therapeutic progress is stifled, clients often remain in therapy for extended periods as they come to rely on the illusory relief conferred by the Construction Worker's "quick fixes."

The Case Scenario: Fourteen-year-old Alison has been experimenting with drugs. Family members are distressed by her behavior and seek out counseling. The mother is the first to bring up Alison's drug use. She says that she thinks Alison's usage might be related to. …when she is abruptly interrupted by the Construction Worker and asked how Alison sleeps at night. The conversation about sleeping continues when the father shares that Alison has been doing drugs now for…again the father is interrupted and the Construction Worker shifts to speak to Alison about school. Alison says she hates school because…and the Construction Worker interrupts her to ask the mother if Alison eats a good breakfast and so the interactional style continues. At the close of the session, the Construction Worker suggests that Alison go to bed an hour earlier and asks the mother to insure that Alison eat breakfast every morning. Throughout the therapeutic process, Alison's drug use and behavior are vaguely discussed and little to no discussion regarding family history about drug usage is encouraged. All questions and conversation are directed toward the Construction Worker and rarely are the family members allowed to speak to each other. During sessions, family members display few conflicts and tension levels are generally low. Family members and the Construction Worker soon become stuck. Interventions

designed to curb drug use fail as Alison not only continues to use, but also with greater frequency and dosage.

The Risk: In order to move out of the professional therapeutic role of the Construction Worker, the therapist must allow clients to speak directly to each other. This is extremely risky for the Construction Workers as they are used to having all conversations directed toward them. A primary goal for the Construction Worker is to communicate to clients that they possess the personal resources that will lead to successful problem resolution and lasting changes. The Construction Worker must utilize techniques designed to enhance productive communications among family members. Through this process, the Construction Worker utilizes client resources to gain and communicate insights into presenting problems and the dynamics that maintain them. In order to achieve this goal, the Construction Worker uses tracking, accommodating, and joining techniques. Several hypotheses need to be developed, tested and acted upon before an intervention can be developed. The Construction Worker operates on the assumption that encouraging information sharing among family members will lead to more effective structural and organizational changes within the system. The biggest risk for the Construction Worker is to slow down, trust the therapeutic process, and avoid offers of quick fixes.

The Alternative Intervention Style-Impasse Busting: There is a number of therapeutic professional roles that the Construction Workers can utilize to deconstruct a face-to-face impasse with a client. Assuming the role of the Journalist provides opportunities to discover key information leading to the symptom. Rather than blocking key information the Journalist discusses issues in greater depth, looks for connections and encourages family members to talk openly about presenting concerns. Adopting the professional therapeutic role of the Archaeologist creates an avenue through which the therapist can explore each person's family of origin, learned child rearing practices, family myths, values, and gender roles, thereby learning how child rearing patterns developed for each parent. Such information is critical because family of origin beliefs and practices frequently undergird symptom development and maintenance. Therapists operating in the professional therapeutic roles of the Detective, the Archaeologist or the Journalist would explore childhood and relational experiences, such as trauma, that may serve to maintain the symptom. Adopting these roles creates opportunities for the therapist refocus sessions on relationship and interactional patterns within the family. By assuming the role of the Referee, the Construction Worker can free himself of blocking family interactions and create a therapeutic environment in which family members learn effective and respectful communication patterns that are practiced in each session. Productive

family communications may serve as a cornerstone on which deeper explorations of presenting problems and underlying dynamics are based. The professional therapeutic role of the Teacher provides similar opportunities to help the clients learn new interactional patterns.

The Techniques: The Construction Worker may employ a variety of therapeutic techniques or tasks within a session or as homework assignments to deconstruct an impasse. Family Genograms, with creative additions such as drug-o-gram, culture-o-gram, organ-o-gram, etc., may be useful to highlight the familial history of each client. These techniques can be used with the goals of illuminating conflicted sides of relationships and exploring the bases of dysfunctional family dynamics. Having the family sculpt how they sees each other in a situation is useful to bring alive various perceptions within the family. The use of puppets as metaphorical objects creates a safer atmosphere for discussing clinically important and potentially volatile family issues. The use of accommodation, tracking and mimesis behaviors within the session provide clients with greater freedom for self-expression while allowing the Construction Worker to join with the family. Furthermore, the application of Contextual tasks may help to change the therapeutic climate so that clients have more room to engage with each other.

The Shake-UP of the Case Scenario: In the above Case Scenario, the Construction Worker began to reflect upon his therapeutic style and realized that his professional behavior was contributing to the impasse and the lack of therapeutic progress. For the next session he decided that the use of a "drug" genogram might prove to be fruitful. In creating the genogram, the therapist instructed all family members to create a list all of drugs (legal and illegal) that they had used throughout their lives and to mark each drug with a "pill container" symbol.

In the professional therapeutic role of the Detective the therapist lead several discussions around the culture of drug use; when prescription and over-the-counter drugs were used to help family member's function and when "illegal" drugs were used. This discussion and development of a drug genogram changed the focus of therapy from Alison's illegal drug use to a discussion of appropriate drug use as an aspect of health maintenance. Use of these strategies, in concert with improved family interactions, resulted in a discussion of Alison's belief that she needed drugs to function more effectively. This discussion also helped Alison gain insight into her need for assistance from a drug treatment center, rather than relying on personal strength to stop using. Family members then tentatively identified aspects of their family dynamics may create triggers and reinforcement for Alison's drug use. The Detective inquired if Alison used "illegal" drugs to escape the family's rigid rules.

Although obviously uncomfortable with the implied allegation, family members listened with concern as Alison discussed the impact of her mother's strict rules on her sense of self-esteem and daily mood. Based on session information, the Detective asked Alison to make two lists of rules: one of which she believed to be fair and one of which she perceived as being unfair. Using these lists in the next session, the therapist adopted the Mediator role to negotiate revised set of family rules with Alison and her parents.

In retrospect, Alison's drug usage was a way for her to escape what she perceived to be overly rigid parental rules. Information gathered during family sessions revealed Alison's sense of impotence in altering these rules, the influences of these rules on her self-esteem and mood, and the power she derived by using illegal drugs. By adopting the professional therapeutic roles of the Detective and the Mediator, the therapist created a therapeutic milieu characterized by attempts to understand and change family dynamics in productive ways. As a result, family members learned to negotiate a set of "revised family rules" that created legitimate power both Alison and her parents, enhanced Alison's self-esteem, and eliminated the need for her to meet needs for power by abusing illegal drugs.

The Reflection: In order to determine if the Construction Worker is your preferred role in a therapeutic environment, it would be helpful to look at:

Family Genogram: Were you the person in the family that would try to stop family members from communicating with each other when tensions escalated by drawing their attention to other things or yelling, STOP!"?

Social Circles: When friends argued would you interrupt them and draw their attention to something else? If you were actively engaged in social clubs, were you the person that stopped brainstorming sessions and tried to suggest a quick fix for the task?

School Experience: As a student, were you the one in the classroom who would get annoyed with long discussions and intervene by getting people to come to a quick solution?

Therapeutic Style: Are you quick to interrupt your client when they attempt to share information and move to another question? Do you often find yourself saying, "NO...NO...NO…. we do not need that information, STOP!"

The Detective

"I spy something very curious, let me look closer!" In the professional therapeutic role of the Detective, the therapist spends considerable energy exploring minute details of clients' lives. No stone is left unturned in looking for clues to describe the "presenting" concerns. The Detective spends most of his time looking for a "guilty" party, who must change his behavior because it is deemed as *detrimental* for the other session members. The Detective is highly focused on either "stated" words or nonverbal interactions observed in the session. The Detective adopts a linear approach to analyze information communicated by family members and accepts such information at face value. The Detective believes that something is "hidden" behind presenting symptoms, which needs to be discovered before the problem can be "fixed". All conversation is directed toward the Detective, who often develops one hypothesis about the origin of problems, presents one solution, and then attempts to convince clients that his solution is "correct" by revealing "uncovered facts." In this process all other viewpoints and hypotheses are rejected. The primary unspoken message to the client is, *I know there is important information that is still hidden somewhere in your history, I will do everything to (help you to) uncover this information.* The Detective, like the Archaeologist and the Journalist has developed an art of asking questions that are used to create hypotheses and which are believed to reveal hidden dynamics that underlie presenting symptoms.

The Positive Use of the Role: The professional therapeutic role of the Detective is positively enacted with clients when presenting concerns are highly complex. The Detective helps to narrow presenting options when opposing viewpoints are provided simultaneously. The professional therapeutic role of Detective can also be used productively when a therapist strongly believes that a hidden dynamic (e.g., a family secret) exists and which serves to maintain the presenting concern. This is a particularly useful role when the therapist believes that the critical information is being withheld that will lead to the development of insights and strategies for addressing presenting problems.

The Seduction-Impasse Contributing: The Detective is seduced into action by clients who come to therapy looking for someone who displays a linear style of thinking in relation to the presenting concerns. In the quest to identify the "one" reason for presenting concerns, the Detective utilizes a connect-the-dot approach. The therapist works very hard by presenting endless questions about each detail. By adopting this role, the Detective devotes inordinate attention to exploring clues that

clients perceive as fruitless and an impasse is created. Clients become bored with the endless barrage of questions and often terminate therapy prematurely.

The Impasse: In his desire to help clients, the Detective laboriously examines clues surrounding presenting problems. Every word or action from the client is overly analyzed and discussed (to the point of boredom). Yet, the Detective treats every detail as critical because he believes that following the trail of client clues will lead to answers and, ultimately, a resolution of client concerns. Even though much information is reviewed, the process limits exploration of ecological systems around the concern, which may serve to maintain it. Tension between clients remains unexposed as endless questioning depletes energy and limits expressions of strong emotions such as anger. This approach creates a structured but sterile therapeutic atmosphere that provides limited opportunities for problem resolution or system change. Clients and the Detective become stuck as information is dissected to the point of uselessness and a therapeutic quagmire develops. Even when the Detective is successful in analyzing clues to "discover" client dynamics, there is a substantial risk that one person in the therapeutic session will be ultimately blamed for the development and maintenance of the concerns. This results in one or more clients being alienated from other family members. Typically, clients remain in therapy for extended periods; despite what they perceive to be insightful questioning by the therapist, their problems persist as progress flags.

The Case Scenario: Six-year-old Tommy has recently begun to wet his bed. This behavior started when he entered first grade at a new school. Tommy's parents seek counseling because they are convinced that his bed-wetting is related to the condition of a new bed that was recently purchased for him. The Detective therapist asks questions about the bed (e.g., "How big is the bed? Is it a single bed? Where in the room is the bed located? Is the bed facing the window or the door? Who may have slept in the bed prior to Tommy?" etc.) Every minute detail regarding the bed, its placement and condition is asked. The therapist further dissects each piece of information provided by the parents (e.g., Father responds: "The bed is a standard bed". Detective: "Now by a standard bed do you mean it is 6 feet long by 4 feet wide?"). The mother declares that she is not sure why this line of questioning is important. She states her belief that school may have something to do with Tommy's concerns. The Detective responds to the mother, "Of course you may not understand my line of questioning, but I need more information." The therapist then suggests that the mother may not know as much as she should about beds and that she has, perhaps, made a bad choice. The father quickly agrees with the Detective that he should have bought the bed. The Detective then continues, "So you say the bed is 6 feet long by

4 feet wide? Does this seem to you like it is a normal size for a bed?" This line of questioning goes on for several sessions as the Detective explores every detail about the bed to the point of alienating the parents.

No interventions are developed. Instead, the family is encouraged to go home, sit on the bed, and then lie on the bed in order to determine if it is comfortable. At no time does the Detective explore other factors that may explain Tommy's enuresis (e.g., stress associated with entering a new school). After five sessions the Detective concludes that Tommy's bed wetting is related to his discomfort in the bed and that Tommy's mother is responsible because she purchased a mattress that is too firm. The mother vehemently reacts to this announcement and yells at the therapist to express her outrage at his conclusion. She says that they have been "spinning their wheels" in therapy, that the therapist has bombarded them with meaningless questions, and that she has had enough. She then turns to her husband and demands that they end therapy because of the therapist's incompetence and that fact Tommy is still wetting the bed.

The Risk: In order to move out of the professional therapeutic role of the Detective, the therapist must refine his interviewing techniques that are already part of his skill repertoire. The Detective must be able to quickly analyze information for the purpose of determining its salience for further exploration. The Detective must use a holistic approach to explore the full range of issues, dynamics, and environmental contexts that may help him and family members understand presenting concerns. This is risky behavior for the Detective because it requires broadening the way he conceptualizes his role and function in therapy as more than a questioner. The Detective must learn to investigate clients' family of origin in order to learn how certain interactional patterns from the past may serve to maintain present concerns. By judiciously exploring the past, key family dynamics may be revealed. The Detective must also learn to use client information to generate multiple hypotheses (vs. a single hypothesis) to help family members understand possible dynamics that maintain the presenting problem. Adopting these strategies will reduce the need to assign blame and create a safe therapeutic atmosphere for all family members. The Detective must further encourage family members to speak candidly about hypothesized explanations with the goals of promoting accuracy, while communication respect for all session members. By implementing the professional therapeutic role of the Clown the therapist will be able to redefine the presented problems and behaviors so that clients can obtain another perspective in a lighter, less tense, way.

The Alternative Style-Impasse Busting: There is a number of therapeutic professional therapeutic roles that the Detectives can utilize to deconstruct a face-to-face

impasse with a client. Working in the role of the Journalist provides opportunities to discern relevant from irrelevant information. Adopting the role of the Archaeologist permits the therapist to study family of origin history that may reveal critical information regarding communication patterns, life style, child rearing practices, family myths, values, gender differences and gender roles. Therapists who adopt the Archaeologist role are well positioned to collaboratively explore and expose family secrets. Both the Journalist and the Archaeologist roles are relatively easy for the Detective to assume because of similarities in requisite skill sets. Working in the professional therapeutic role of the Bird Watcher creates opportunities to observe nonverbal interactions in and between family members as well as to listen carefully to the content of spoken communications. The professional roles of the Angel and the Savior permit the therapist to demonstrate warmth, empathy, and concern and to join with the family. Adopting the role of the Clown creates opportunities to interject humor and creativity when sessions take on an overly serious tone, but this role may be more difficult for the Detective to adopt due to the serious nature of detective work.

The Techniques: The Detective could employ a variety of therapeutic techniques or tasks within a session or as homework assignments to deconstruct an impasse. Tracking and accommodating clients enable the therapist to join and be part of the client system. The Detective must refine his interviewing techniques by using questions judiciously while attending only to information related to presenting concerns. He may also use circular questioning ask questions in a more relational way.
Genograms can serve as a backdrop for the development of focused questions asked by the Detective. The use of family genograms creates opportunities to focus on past issues, relationships, and dynamics that may reveal family secrets, which silently maintain presenting concerns. By understanding these dynamics, the Detective can discern and reconstruct patterns that lead to a new structural organization, which may promote deeper client understanding and more rational thinking about presenting concerns. The Detective may also employ constructual tasks and reorganizing patterns to alter session tone and dynamics. By using displacing tasks, relabeling tasks or moving to a new symptom, the therapist may help clients to productively re-focus the target(s) of their attention. The use of metaphorical objects can be helpful in discussing concerns and can be quite dramatic as it helps to produce insight for clients regarding their rigid state of communication.

The Shake-UP of the Case Scenario: In the case scenario, the Detective was made acutely aware of his clients' dissatisfaction with therapy, especially by the mother's angry outburst and rejection of his hypothesis. The mother's anger and resistance

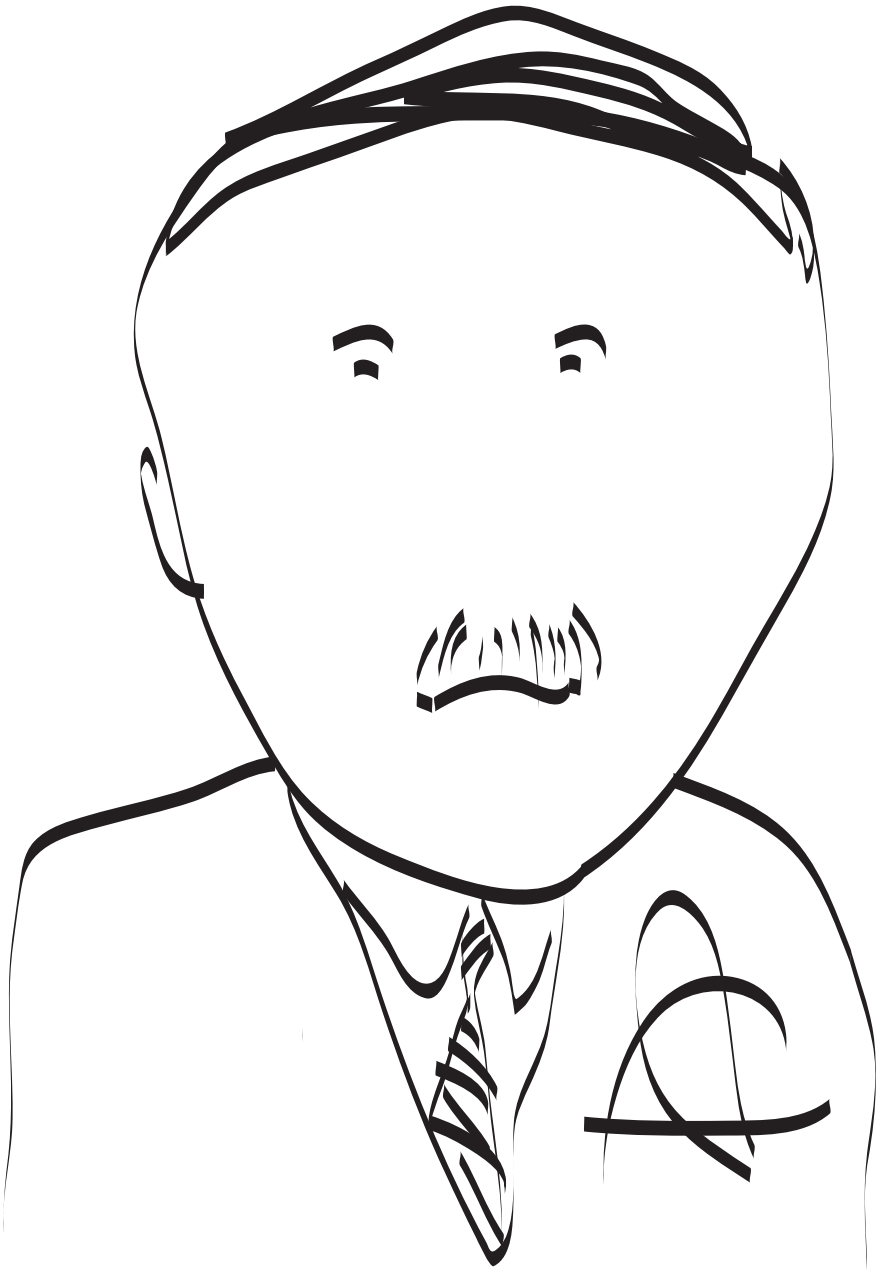
initially annoyed the Detective. However, on brief deliberation, he shifted into the professional therapeutic role of the Journalist and asked first the mother and then all the family members about their understanding of Tommy's bed wetting. He used a calendar to establish connections between Tommy's school and bed-wetting experiences. As the parents and Journalist reviewed the calendar, it became apparent that Tommy only wet the bed on weekdays; on weekends his bed remained dried. The therapist then moved into the professional therapeutic role of Teacher and explored with Tommy's parents the anxiety he may have experienced on entering the first grade and struggling to adjust to a full day away from home. The Teacher then discussed the role that learning deficits can play in creating anxiety and suggested that the parents consider meeting with Tommy's teacher to determine if evidence exists to suggest the existence of a deficit. The parents readily agreed to this request. In the next session, they reported that the teacher had shared that Tommy was experiencing a great deal of difficulty with reading and was refusing to go to his assigned reading group. The parents and teacher mutually decided to request that a Tier-1 intervention be developed for him in the classroom. The therapist then shifted into the professional therapeutic role of the Doctor. With parental support and information, the Doctor developed a behavioral plan designed to address both the enuresis and reading problems.

In retrospect, Tommy's bed wetting was related to the stress he experienced by being separated from his parents during the school day and to his distress associated with poor reading ability. Tommy felt like he was going to fail in school and did not know how to tell his parents that school was hard for him.

The Reflection: In order to determine if the Detective is your preferred role in a therapeutic environment, it would be helpful to look at:

> **Family Genogram:** Were you the person in the family who asked questions about every concern that arose in your family to the point where people may have gotten angry at you?
>
> **Social Circles:** When friends disagreed, would you pester them with questions about the details of their thinking? If you were actively engaged in social clubs, were you the person who interrupted business by constantly interjecting questions?
>
> **School Experience:** As a student were you the one in the classroom that would ask too many questions of the teacher about a task or homework assignment? If other students presented an idea, would you persistently question them about it?
>
> **Therapeutic Style:** Do you find yourself asking question after question without looking at the ecological aspects the presenting concerns? Do you often find yourself saying, "Ahh…clues, I need more information!"

The Doctor



"Now let me see. I believe that I would classify her as a...let me review my notes here…yes, as a classic borderline." This professional therapeutic role derives its power and legitimacy from the medical profession. The Doctor uses medical terminology from the Diagnostic and Statistical Manual of Mental Disorders-Fourth Edition-Test Revision (DSM-IV-TR) and views most problems as existing within the individual. More specifically, the Doctor views one of the family members in the session as the "patient" (a.k.a. the "identified patient" or "IP") and other family members as healthy. The therapist frequently relies on psycho pharmacological treatments and regularly refers clients for medical/psychiatric evaluations. Most importantly, the patient is viewed as creating an ineffective and pathological interaction in the family system. Thus, members within the patient's systems must be helped to cope with the patient's pathological behavior. Consequently, if the Doctor uses a family oriented approach, it will incorporate a psycho educational focus. At various points in the therapeutic process, the professional therapeutic role of the Doctor may intersect with the professional therapeutic role of the Teacher.

The Doctor usually accepts and does not challenge family members' definitions of the patient's illness and remains emotionally detached from clients during sessions. The Doctor tries to make people healthier by listening to clients describe their health problems and by conducting psychological or neurological tests in an attempt to identify a specific disorder. The Doctor frequently gives advice about diet, exercise, and sleep. All conversation is directed toward The Doctor who, because of his preeminent position in the session, is rarely questioned. At times the Doctor may interview clients from behind his desk. The primary unspoken message to the patient is that you are suffering from mental illness. I will diagnose a specific disorder and prescribe the best treatment.

Therapists who are insecure in their ability to relate effectively to clients or to intervene skillfully with the clients' presenting concerns often assume the professional therapeutic role of the Doctor. Thus, rather than examine family structure and ecological contexts for possible answers, the Doctor looks for solutions in medical books. He dares not explore the influence of family members' interactions on symptomatic behavior in the presence of a medical or somatic illness because the Doctor fears that clients will feel blamed for the illness of their patient.

The Positive Use of the Role: The professional therapeutic role of the Doctor is positively enacted when a somatic concern influences not only the patient but also

the mental health and well-being of other family members. Adopting the role of the Doctor is appropriate when clients (i.e., family members) are unable to comprehend the somatic concern and claim that the identified patient only wants sympathy. For example, a family may be in denial about the traumatic effects caused by a minor car accident. The patient's behaviors consist of dysomnia, concentration problems, disturbed focusing, memory problems and irritability. Family members may fail to understand the relationship between the car accident and the patient's symptoms, claiming that the patient only wants sympathy. In this case, the Doctor recognizes these as typical symptoms of a mild traumatic brain injury.

Adopting the role of the Doctor requires that the therapist has completed legally mandated training and possesses a comprehensive understanding of various medications, including mechanism of action, indications, contraindications, drug interactions, allergic reactions, and how prescribed medications may affect the patient's physical and mental health. Working in this professional therapeutic role provides opportunities to analyze the impact of various pharmacological drugs on client behavior and to explore the etiology of somatic concerns.

The Seduction-Impasse Contributing: The Doctor is seduced into action by clients who present with either somatic complaints or who clearly present an identified patient. Clients may have selected the Doctor based on his expertise in treating a particular medical condition. Patients may or may not have a clear medical diagnosis. The role of the identified patient (IP) is fixed in the therapeutic session, and the patient is not allowed to change this role. The therapist may assume the role of the Doctor in order to "protect" clients by preventing them from discussing serious concerns or expressing strong emotions. In this process the Doctor unwittingly creates an impasse.

The Impasse: In an attempt to shield the family from further pain, the Doctor educates family members about the patient's condition and the impact of the patient's somatic concerns on the family system. In order to insure an accurate diagnosis and treatment consistent with best professional practices, the Doctor may consult with other medical professionals. Confident in his understanding of client and patient concerns, the Doctor will frequently make a diagnosis and suggest various pharmacological or behavioral approaches designed to alleviate the somatic concern.
The Doctor commonly obtains information needed to understand the patient's somatic symptoms, but does not gather information required to understand the systemic dynamics that created or maintain the symptom. Family interactions and mental health needs are rarely considered. As a result, the Doctor and clients become

stuck because the root of the problem is never investigated. Clients and/or the identified patient have little hope of making therapeutic progress because the dynamics of symptom maintenance and the rigid roles that family members assume around the illness are never explored. By adopting this approach, the Doctor sabotages the therapeutic process and encourages client dependence. Equally detrimental is the fact that clients fail to learn that they possess the power to influence the presenting symptom in a positive way.

In such circumstances, clients often come to believe that their situation is hopeless, especially when they feel powerless over the problem or its solution. When they fail to experience change, while believing that the therapist has done all that is possible, clients frequently terminate therapy and search for new therapist who will also "fix" the identified patient in his therapeutic role of the Doctor.

The Case Scenario: A family of three, mother, father and son of twenty-four, enter therapy. A previous therapist has diagnosed the son with "a schizophrenic illness." Observing the session behind a one-way mirror is a team of therapists-in-training and a co-therapist. The treating therapist has an excellent reputation for working with clients diagnosed with schizophrenia. Through questioning, the Doctor learns that all family members agree with the previous diagnosis, have determined their roles around the identified patient, and have adapted to these roles without problem. Each member asks questions about cognitive problems evidenced by the patient, prescribed medications, and things they can do to prevent another psychotic episode. The parents tell the Doctor that they believe that their son will be required to live in their care for the rest of his life. In his role as Doctor, the therapist happily devotes more than eighty percent of the session to answering questions. Family members feel relieved by the Doctor's answers and are impressed by his authoritative and reassuring manner. They request permission to schedule another appointment should the need arise. In this session, the Doctor unwittingly creates an impasse by using his authority to foster client dependence and failing to help clients identify goals for change.

The Risk: In order to move out of the professional therapeutic role of the Doctor, the therapist must become more self-aware of the hubris that too often maintains this role and demonstrate empathy in the session by interacting in more caring ways with clients. The therapist must view clients, first and foremost, as human beings with human problems and to work diligently to understand their concerns from holistic, systemic, contextual viewpoints. He must practice effective interviewing techniques and ask questions that will lead to an understanding of clients' interactional patterns that may be maintaining or exacerbating somatic presentations. Such changes are

extremely risky for therapists operating in the role of the Doctor because they are most comfortable with knowing that they have all the answers. Therapists whose primary presentation to clients is in the role of the Doctor are generally insecure in their ability to relate to clients with empathy, genuineness, and positive regard and often lack confidence to respond effectively to clients' presenting concerns.

The Alternative Intervention Style-Impasse Busting: There is a number of professional therapeutic roles that the Doctors can utilize to deconstruct a face-to-face impasse with clients. Working in the role of the Teacher provides opportunities to educate family members about the development and maintenance of somatic problems as well as the pharmacological effects of prescribed medications. Adopting the role of the Journalist enables the therapist to gather enough information about somatic concerns to make proper referrals. Assuming the role of the Archaeologist makes it possible for the therapist to trace similar symptoms in extended family members and identify possible genetic predispositions for symptom development. In an effort to discern rigidified roles that may serve to maintain somatic concerns, the therapist may adopt the professional therapeutic role of the Bird Watcher in order to observe verbal and nonverbal interactional patterns in and among family members. Therapists who assume the role of the Construction Worker are poised to block rigidified behavioral patterns toward the symptom. Adopting this role also creates opportunities for the therapist to help family members reorganize the family system and practice more productive individual and systemic responses to the somatic concern. Adopting the roles of the Angel and the Savior enable the therapist to demonstrate empathy and care for clients, thereby creating trust and the basis for a therapeutic alliance. Operating in the professional therapeutic role of the Firefighter provides opportunities to challenge and modify rigidified family roles that serve to maintain the somatic concern. The the use of the professional therapeutic role of the Detective is beneficial when the presenting concern of the clients is highly complex and many different viewpoints are needed to be expressed. By implementing the professional therapeutic role of the Clown the therapist will be able to redefine the presented somatic problems and behaviors so that clients can obtain another perspective in a lighter, less tense, way.

The Techniques: The Doctor can employ a variety of therapeutic tasks or techniques within a session or as homework assignments to also deconstruct the impasse. For example, the therapist may work to change how family members respond to a somatic concern by exaggerating the symptom, de-emphasizing the symptom, moving to a new symptom and/or replacing the symptom with other concerns to break the members' hyper focus on the symptom. In order to modify family members'

rigid reactions toward the patient, the therapist may opt to alter the affect of the symptom on the clients' system. The therapist may further consider using tasks of alliance (e.g., who responds to whom regarding the symptom) or paradoxical tasks (e.g., prescribing the symptom or prescribing rules of how one reacts toward the symptom) with the goal of imploding idiosyncratic rules and behaviors around the symptom. Additionally, the therapist may block unproductive behaviors around the symptom, construct new ways of relating to the somatic concern, reinforce useful behaviors towards the somatic concerns, and reorganize the family around the presenting somatic concern. Adding systems permits the therapist to assist the family in seeking out additional resources to help them in caring for the identified patient, while disassembling tasks may reduce nonproductive reactions toward the somatic concern and introduce flexibility into the system. By Developing a Somatogram(genogram with focus on how people communicate through "organs" /somatic symptoms) can help the clients visually how overly involved or uninvolved each client is with the somatic concern. Clearly, employing a variety of techniques affords the Doctor greater flexibility in providing competent patient care.

The Shake-UP of the Case Scenario: Near the end of the session in the above scenario, the co-therapist behind the one-way mirror came into the session with a tea bag in his hand and told the therapist that he fell asleep because the session was so boring and that he had learned nothing new about the family. As he handed the teabag to the therapist, the co-therapist said, "You try to become the teabag and give taste to the conversation as a teabag gives taste to the hot water. But it must not be you who brings the taste to the conversation but the family that makes the discussions tasteful."

The co-therapist then left the Doctor and family alone with the teabag. The father spoke first. He said, "What a strange man. I think he was very impolite towards you." "Yes," the mother added, "I think you are doing very well with us, isn't he?" asking the son, who readily agreed. The Doctor thanked the family and said, "Indeed, I also feel a bit shocked, but I know my colleague very well. I am sure that his point was an important one, so let's talk about his idea." The family agreed. After some discussion about tea and making tea, the Doctor asked the family members to go home and choose some tea that each member loved to make and to bring it to the next session two weeks later. The Doctor promised to bring a pot of hot water to make all of the teas.

At the next session, each member brought his/her special tea: the mother brought an English breakfast tea, the father had chosen a special blend, and the son, who had carefully considered the therapist's assignment, brought a special mixture

of Indonesian teas. The Doctor provided a large pot of hot water and four cups and all members of the therapeutic system tasted the different teas. This experience prompted a discussion about the diversity and differences between family members and the son's daring choice. At this point, the therapist was well positioned to abandon his professional therapeutic role of the Doctor and adopt the role of the Detective. In this new role, he was able to ask all family members about their differences in tastes, beliefs, values, visions of the future, etc. During the discussion, it became apparent that the son had a desire to leave his home and try to live on his own.

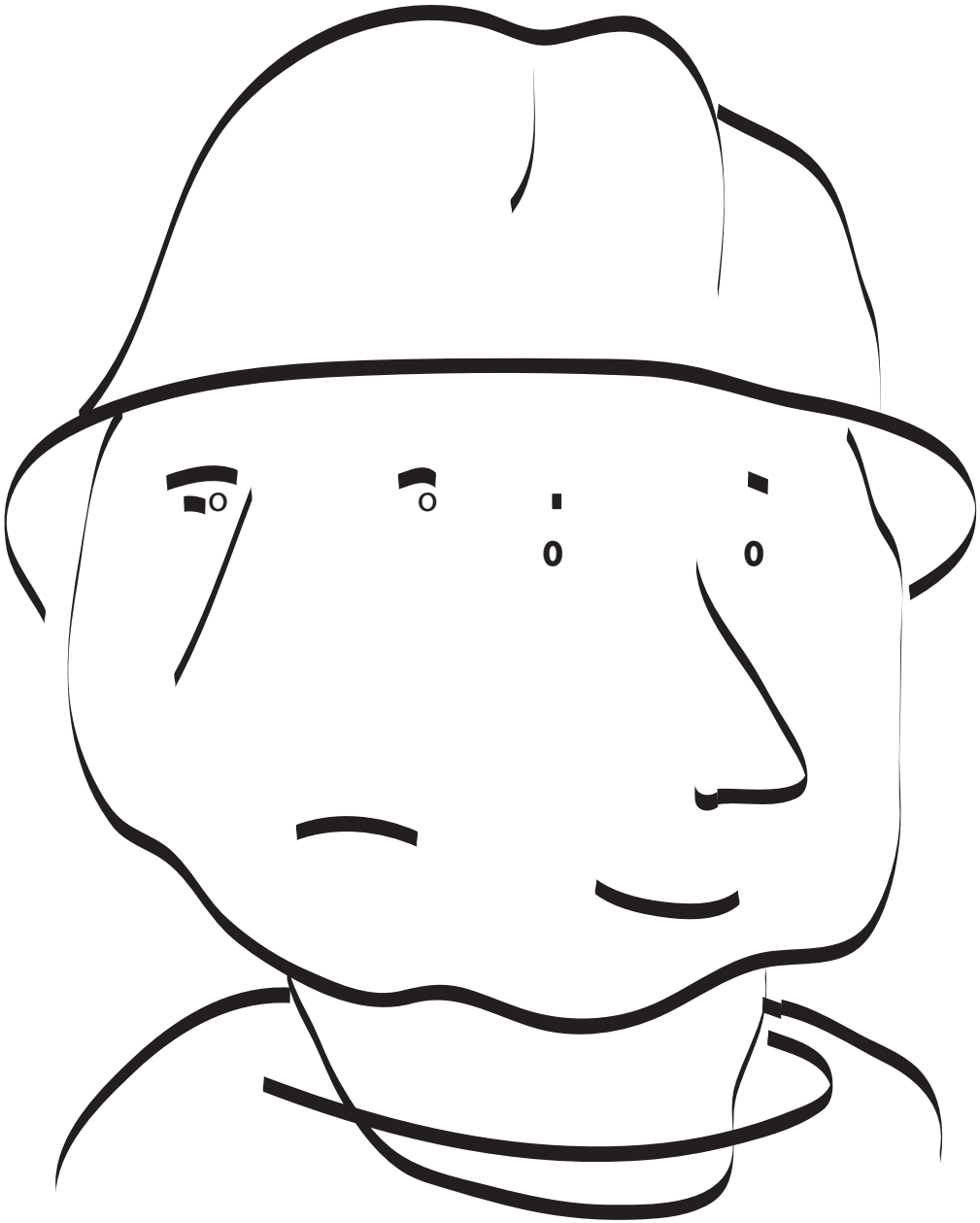
Near the end of the session the co-therapist, who had once again observed the session, entered the room and stated that he was very curious to taste the special tea provided by the son. He told the family and acting therapist that he had been very interested in the work accomplished during the session and that at no time had he felt bored. Before the session ended, the son requested another appointment to discuss his wish to leave home and his future. The therapist, parents, and co-therapist acknowledged the son's request and commended him for his courage and personal strength in taking this action.

In retrospect, the family had created a homeostatic system in which the parents had accommodated the belief that the son would never leave home. The parents rarely listened to their son, who had very different beliefs, values and wishes, but who was only able to express them through his schizophrenia. When the therapist revised his professional therapeutic role from the Doctor to the Detective, he created a therapeutic milieu in which it was safe for family members to discuss differences in ideas, beliefs, and wishes through the metaphor of the teas.

The Reflection: In order to determine if the Doctor is your preferred professional therapeutic role in a therapeutic environment, it would be helpful to examine:

> **Family Genogram:** Was I the person in the family who read books in hopes of determining which of my family members was sick or had a mental illness?
> **Social Circles:** When friends acted strange, was I the person trying to figure them out by diagnosing them? Was I often thinking that my friends were sick or had a mental illness? If I was actively engaged in social clubs, was I the person trying to allay others' fears by educating them about phobias or unusual behaviors?
> **School Experience:** As a student, was I the one who took interest in reading about medical or psychological problems and reporting back to classmates?
> **Therapeutic Style:** Do I rely on the DSM-IV to diagnose clients and regularly send them to other specialists for additional medical or pharmacological assessment and treatment? Do I often find myself saying, "They need medication" when tensions arise rather than allowing the conflict and tension to direct me?

The Firefighter



"Watch out Watch out! Let me in, I am here to help!" The professional therapeutic role of the Firefighter requires the therapist to adopt a crisis-oriented approach as he is typically busy "putting out fires." The Firefighter is quick to respond to emergency situations and works to rescue clients from all types of emotional disasters. The Firefighter therapist is able to assess situations quickly and decide on the best course of action for clients. He is able to respond quickly to unforeseen circumstances as they emerge. Typically, the Firefighter will collect only minimal information from the clients before moving into action. The Firefighter usually accepts and does not challenge the clients' definition of the identified patient's illness. Through these processes, the Firefighter often becomes reactive to presenting issues; he takes action to save the client or "victim" from further distress and works to help clients return to a level of "normalcy." The Firefighter strives to create a sense of emotional safety for clients by minimizing the distress, emotional suffering and tensions caused by the crisis. In the professional therapeutic role of the Firefighter the therapist becomes enmeshed in the clients' symptoms. Typically, all communication is directed towards the Firefighter. The primary unspoken message to clients is "you need me to solve your problems." Often the Firefighters will maintain links with local community agencies and work hard to educate their clients on strategies designed to promote emotional well-being.

The Positive Use of the Role: The professional therapeutic role of the Firefighter is positively enacted when clients are in crisis. There are, of course, times and circumstances in which quick, directive intervention techniques are appropriate and necessary. This professional therapeutic role allows the therapist to help the clients move past the crisis with the goals of refocusing the session on altering clients interactional and communication styles to create a "normal" level of functioning.

The Seduction-Impasse Contributing: The therapist is seduced into action by clients who are very volatile and who present in crisis. Of course, clients do sometimes come to therapy with real and atypical crises that must immediately be addressed. However, certain types of clients (e.g., those who present with borderline or histrionic tendencies) may present a new crisis in nearly every session. These clients actively seek out Firefighter therapists to solve their crises based on feedback from others regarding his abilities to resolve such situations. Commonly, clients present to the Firefighter as an identified patient in crisis while other family members in the session appear helpless to help. Such clients ordinarily contact the Firefighter

between sessions to assist them with solving the crisis of the moment. Through this type of therapeutic process, clients become highly dependent on the Firefighter. A therapist who is seduced into the professional therapeutic role of the Firefighter is often very good at solving crisis situations through quick fixes. However, clients and family members pay dearly for them. By working to create a "safe" therapeutic environment and to "protect" clients from further distress, the Firefighter inadvertently prevents explorations of serious concerns and powerful emotions that typically underlie presenting crises. In this process, the Firefighter is seduced into action that contributes to an impasse.

The Impasse: Feeling compelled to resolve the presenting crisis and client distress as quickly possible, the Firefighter is very quick to make a diagnosis and to use interventions designed to resolve or "band aid" presenting problems. The Firefighter collects only enough information related to understanding the crisis before he acts. As a consequence, the clients' system of interactions and symptom maintenance are rarely analyzed and progress is thwarted. As clients present crisis after crisis, the Firefighter may become overwhelmed. In such cases, clients may become angry if the therapist does not react quickly enough to their demands or blocks their attempts at contact. Thus, an impasse develops. As clients bounce from crisis to crisis, they commonly become dependent on the Firefighter and remain in therapy for an extended period. Once attached to the Firefighter, clients typically remain attached. However, some systems, particularly those with a member diagnosed with borderline features, may become dismayed or angry and "try out" another therapist only to return to the "original" therapist at a later date.

The Case Scenario: Belinda is married with two children. She comes to the session with her mother, who is concerned about Belinda's behavior. The mother reports that Belinda is not sleeping, appears to be having "manic" episodes, and experiences racing thoughts. She further reports that Belinda leaves her family for periods of several days during which she meets men at truck stops and engages in various sexual behaviors. At other times she reportedly goes on extensive shopping sprees and spends well beyond the family's budget, which forces her mother to repeatedly pay her credit card bills. The mother reports that this behavior has continued for six months, during which time she and her daughter have seen six therapists, none of which have helped them.

The Firefighter quickly develops an intervention designed to curb Belinda's shopping sprees by having her cut up all of her credit cards during the session. The family leaves with hope that Belinda's behavior will improve. Within two days, the Firefighter receives a phone call from Belinda's mother, who reports that Belinda

has gone on another shopping spree after she ordered a new credit card on line. The family immediately returns to therapy for a "crisis" session. The Firefighter suggests that family members carefully monitor Belinda's time on the computer and program the computer to limit her access to certain sites. After implementing the plan that same day, Belinda's mother calls the therapist that evening to report that Belinda has left home and cannot be found. The family is worried and requests an immediate session to develop a plan of action. The family comes to therapy the next morning and a discussion ensues about reporting her as a missing person to the police and to do this each times she leaves unexpectedly. The family returns home to find Belinda sitting in the living room, unwilling to provide explanations as to her whereabouts.

A few days later Belinda is depressed and talks to her mother about killing herself. Belinda's mother immediately notifies the Firefighter, who orders her to take Belinda to the emergency room, where he will meet them. This scenario is repeated several times within the following three months and each time the Firefighter is quick to initiate a crisis intervention session with family members. One day, Belinda tries to reach the Firefighter when he is on vacation and becomes violently angry when she is told that he is not available. Even though the Firefighter has arranged for another therapist to serve his clients while vacationing, Belinda refuses to speak with this professional and demands to speak directly to her regular therapist. When she does not get her way; she calls another local therapist to make an appointment.

The Risk: In order to move out of the professional therapeutic role of the Firefighter a therapist must be skillful in blocking the transactional patterns of clients and being less reactive to presenting concerns. The greatest risk for the Firefighter will be to slow down, track and accommodate clients and resist the desire to develop a quick intervention for resolving the presenting issue. The Firefighter must ask focused questions in order to determine how members within the therapeutic system handled themselves in similar situations. The Firefighter must further teach family members how to assess the accuracy of information so that erroneous reports do not fuel inappropriate reactions. In addition, the therapist must teach members within the therapeutic system how to organize themselves when a crisis does arise. Thus, the Firefighter is required to develop techniques that empower members of the therapeutic system to resolve their own crises.

The Alternative Intervention-Style Impasse Busting: There is a number of professional therapeutic roles that the Firefighters can utilize to deconstruct a face-to-face impasse with a client. Adopting the professional therapeutic role of the Journalist will allow the therapist to objectively gather sufficient information regarding the presenting concern to be able to develop effective interventions. Working in this professional

therapeutic role also allows the Firefighter to slow down, thereby reducing the possibility of a reactive response. Assuming the role of the Detective would enable the therapist to uncover hidden agendas that fuel the client's behavior. Embracing the role of the Archaeologist would provide opportunities for the therapist to trace back similar symptoms and behaviors in extended family members, which may provide clues to explain problems with symptom remission. Through this process the Firefighter may also learn how other family members responded in similar situations. Adopting the role of the Doctor may be useful for making a psychiatric diagnosis. Switching to the role of the Archaeologist may facilitate an investigation of how manic or depressive reactions influence both extended and immediate family members and their responses to the patient with bi-polar disorder. Assuming the role of the Teacher provides opportunities for the therapist to help clients understand and respond productively to an individual diagnosed with a personality disorder. The therapist can also teach the members in the therapeutic system how to organize themselves around a crisis. Taking on the Construction Worker role may help the therapist to block erroneous information that ignites and rekindles crisis situations as well as limit client contacts with the therapist between sessions. Adopting the professional therapeutic role of the Clown creates opportunities to introduce humor into a session, alleviate tensions typically present in crisis situations and help clients view their concerns from a different perspective.

The Techniques: The Firefighter may employ a variety of therapeutic techniques within a session, as homework assignments or tasks to deconstruct an impasse. For example, he may employ countersystemic tasks to challenge homeostatic family systems, system restructuring to help clients move beyond persistent states of crises and reinforcing tasks to solidify interactional behaviors or communication styles that promote rational thinking and emotional balance. He may use interviewing techniques to obtain contextual information that maintain client symptoms and family genograms to reveal the basis for presenting concerns or recurring crises within the system. The therapist may further employ genograms to reveal transgenerational issues. He can assign metaphorical tasks to break down rigid family boundaries and, when appropriate, elevate stress levels within the therapeutic session.

The Firefighter may need to add or subtract members within a therapeutic system in order to create structural change and implode family members' reactivity to the IP's behavior. Altering therapeutic members' affect may alleviate or create more productive responses to the presenting symptom. In assessing enmeshment within families, the therapist could disassemble the system by emphasizing differences among its members.

The Shake-UP of the Case Scenario: Based on information provided in the case scenario above, the Firefighter returned from vacation to learn that Belinda had established an alternative therapeutic relationship. However, within three weeks of his return, Belinda called to make another appointment. Upon her return to therapy with her mother, Belinda announced that the other therapist was "stupid" and that she had quit. At this point the Firefighter assumed the role of the Archaeologist. He inquired about times in the family's history when Belinda had exhibited similar behavior and how family members had responded. The mother reported that her mother was very depressed and at times displayed manic behaviors. The therapist then shifted into the professional therapeutic role of the Doctor and shared his diagnosis of Belinda's problems as bi-polar disorder. The Doctor said that he would employ both a psycho-educational and medical management approach with the family and the patient to help manage the manic-depressive episodes. To help Belinda and family members cope with periods of elevated mood and manic behavior, the Doctor collaboratively developed a crisis management plan with family members and friends to insure that Belinda's behavior would be comprehensively monitored and her safety insured. Before leaving the session, the therapist shifted to the professional therapeutic role of the Teacher. He suggested that family members collectively identify and buy a book on Bi-polar disorder in families and that all members read and discuss it in preparation for the next session.

In retrospect, the Firefighter initially responded so quickly to Belinda's bi-polar episodes that he could not implement the necessary therapeutic tool required to understand or address her concerns. He was only able to activate these tools and other resources after he shifted into the professional therapeutic role of the Doctor, which enabled him to accurately diagnose the problem, develop a clinically-supportable treatment plan, and implement interventions designed to benefit both the patient and family members.

The Reflection: In order to determine if the Firefighter is your preferred professional therapeutic role in a therapeutic environment; it may be useful to examine:

Family Genogram: Were you the person in your family who became reactive when disagreements surfaced and family members argued? Did you react to these situations by developing interventions designed to reduce tensions?

Social Circles: When friends argued or behaved in an erratic way, did you try to help by intervening? If you were actively engaged in social clubs, did you quickly intervene to diffuse mounting tensions among club members?

School Experience: Were you the class member who reacted quickly if other students became annoyed with a situation?

Therapeutic Style: Do you find yourself reacting, and not responding, to client problems? When a client frequently (i.e., after hours, on weekends) calls you to discuss a concern, are you quick to react and intervene? Do you often find yourself saying, "I need to do something now?

The Journalist

"You mentioned that when you were small you liked playing with dolls. Can you share with me a time that you remember as being very special?" The Journalist assumes a role of wanting to get to the root of the problem by helping clients present their life stories and experiences in a clear and engaging style. He collects and disseminates information about current family events, family interactions, trends, and situations around the presenting issues. When employing the role of the Journalist, one needs to be curious about how the family arrived at their current interactional state. Prior to making a hypothesis, the Journalist develops and asks questions about the processes around a symptom. The therapist's use of detailed questions permits all aspects of the interactions around the symptom to be revealed. Extended family members may be included in a session in order to gather more relevant data regarding how a 'symptom' maintains the client's dysfunction. The Journalist attempts to gather as many points of view from as many different sources as possible. Throughout this process, the Journalist maintains a neutral posture, does not judge others and remains impartial as information is collected.

The Journalist is not afraid to ask tough questions when necessary. The Journalist intentionally directs communications away from himself and to family members. In this process, family-to-family interactions are encouraged and the Journalist collects information from them. The Journalist works to commit critical information to memory. After the session, he records progress notes and utilizes this information to discern more about the couple's or family members' interactions and communication styles around the presenting concern. The Journalist provides feedback to the family regarding the ideas and hypotheses that he develops. Based on the Journalist's presented hypotheses, family members decide how they should alter their interaction system. The family is responsible for selecting the solution to the "presenting" problem.

The Journalist's primary unspoken message to the clients is that what you have experienced in life is important, has value, and is of interest to others. In other words, "Your stories hold the key to helping you move forward in life". The therapist takes an active role in the session by asking questions and guiding clients to deeper levels of self-exploration and personal revelation. The Journalist effectively balances what clients share through narratives while limiting self-discloses to a threshold below feeling emotionally overwhelmed or reactive. The Journalist is comfortable in allowing tensions to develop within the session and is able to remain cool under the

resulting pressure. The Journalist will actively suppress or lower tensions experienced by clients through the skillful use of questions.
Journalists relate effectively to all kinds of people. They communicate interest in and respect for clients, while efficently absorbing large amounts of information communicated during therapy sessions. Adopting the professional therapeutic role of the Journalist creates opportunities to gather a wealth of information about the family system, including the ways in which it maintains presenting issues. Access to such information positions the therapist to develop interventions designed to promote lasting individual and systemic change.

The Positive Use of the Role: The professional therapeutic role of the Journalist is positively enacted in almost all situations presented by clients. By asking questions and providing opportunities for clients to share their stories and perceptions, the Journalist introduces hope and a sense of session calmness that permits clients to relate to each other on a more functional interactional level. The Journalist helps the clients to examine positive and negative aspects of family relationships without judging. He models for others how to be curious, inquisitive, and open to all information that is presented. The Journalist remains poised when tensions arise and clients leave sessions with a sense that regardless of how serious their situation may be, there is hope. The professional therapeutic role of the Journalist is especially useful with clients who experience panic or helplessness in various life circumstances. Like the Archaeologist and Detective, the Journalist is particularly skillful in using questions to reveal conflicts that maintain presenting symptoms. Because the Journalist presents to all clients as inquisitive, curious, and unafraid to ask difficult questions, he is able to build therapeutic rapport and win the confidence of a wide variety of clients.

The Seduction: Impasse Contributing: The Journalist role is seduced into action when clients enter a session and present as disengaged or silent. Family members rarely speak and their nonverbal behaviors are sparse. Session members often sit in silence for long periods of time and stare straight ahead. Regardless of any information communicated, clients remain detached and under-reactive. If the therapist demonstrates curiosity or asks questions about observed session behaviors, family members typically ignore the therapist and persist in their dysfunctional silence. Attempts by the Journalist to create a dialogue by asking additional questions or probing aspects of the family system are met with more silence and emotional distancing, which further contributes to the impasse.

The Impasse: A therapist operating in the professional therapeutic role of the Journalist may use questions to explore hidden family conflicts that he believes are

maintaining presenting symptoms. In such situations, clients typically respond in positive ways to the inquisitive nature of the Journalist. However, when clients are disengaged and refuse to talk, continuing to ask probing questions may irritate clients to the point of producing a complete breach in the communication process. In such circumstances, discussion is avoided and both clients and the Journalist become stuck. The Journalist may feel trapped in a double bind as clients request help but refuse to talk or answer questions. In reality, clients are typically pleased with these circumstances because they preclude hope of exploring uncomfortable emotions and underlying conflicts. Although clearly not in their self-interests, family members resist efforts by the Journalist to instill hope for change. Typically, disengaged clients quickly terminate therapy even as they express concerns that the presenting symptom has not changed.

The Case Scenario: The Shenker family entered therapy at the request of a school psychologist who had communicated concerns that the youngest son, Tommy, was extremely withdrawn and that he rarely interacted with anyone. The family consisted of four boys, a natural mother and stepfather. Upon entering the room, all family members looked agitated, sat down and stared straight at the floor. The Journalist welcomed all family members and names were exchanged.

He then asked the mother about any concerns she had regarding Tommy's behaviors. Her response was, "None." The Journalist asked similar questions of each family member and all replied with the same one word comment. The Journalist then asked Tommy about his experiences at school on a typical day. Tommy remained silent. The Journalist then questioned the three brothers about their experiences at school. All of his probes were met with stony silence. He then turned to the stepfather and asked what it was like for him to join his new family three years ago. The stepfather glared at the Journalist and said that he was beginning to get annoyed by the questions being asked. The Journalist then asked the mother about how the boys got along at home.

At that moment the Journalist saw something shiny out of the corner of his eye and noticed that the oldest brother had pulled open a switch blade and was moving his hand up and down the blade while staring at the floor. The Journalist asked the adolescent about his fantasy with the knife and was again met with unfeeling silence. The stepfather said that he had "just about enough" of the questioning and was ready to leave. At that point the family rose and left the session. The next day, the school psychologist phoned to say that Tommy had withdrawn from school, but that no forwarding information had been provided. Later that afternoon, the school psychologist drove past the family's home only to find that it was empty.

The Risk: In order to move out of the professional therapeutic role of the Journalist a therapist must practice great patience. He must demonstrate respect, empathy, and a concern for family members, but refrain from asking questions until he has been able to establish a safe environment. The Journalist must trust that, working patiently and purposefully, he can slowly create the conditions necessary to establish therapeutic rapport. These are extremely risky tasks for the Journalist, who has plied his craft by asking questions, being curious, and relying on clients' expertise to discern problems and their underlying dynamics. The therapist must resist his immediate impulse to ask questions and instead, adopt an accommodating and tracking approach to clients' silence. In order to effectively make this transition, the Journalist must become less active and strive to create a session environment that accommodates both strong emotions and silence. Concurrently, he must patiently encourage clients to take risks by participating in the session at their own pace. With patience and time, clients may come to feel safe in expressing concerns. The Journalist may be able to promote client interactions and discussions of tensions around the symptom that are designed to resolve the presenting problem.

The Alternative Intervention Style-Impasse Busting: There is a number of professional therapeutic roles that Journalists can utilize to move beyond a face-to-face impasse with disengaged clients. Assuming the role of the Bird Watcher creates opportunities to join the detached system and gather relational information around the symptom via nonverbal communication. This information can be used to analyze areas of discontent and stress in and among clients and may be helpful in restructuring the system. Adopting the professional therapeutic role of the Clown may be useful when excessive silence or hostile disengagement creates a gloomy session atmosphere and humor is needed to provide relief. Embracing the role of the Angel provides the therapist with opportunities to build the therapeutic alliance by creating a safe physical and psychological environment, communicating a genuine desire to help, and demonstrating empathy for the difficult circumstances faced by family members. When an impasse develops, the Journalist must be able to shift both therapeutic roles and techniques. He must abandon the relative safety of asking questions and adopt the more discomforting and difficult skill of using therapeutic silence to permit the emergence of client communications that provide insights into client's family structure and dynamics.

The Techniques: The Journalist may employ a variety of therapeutic techniques or tasks within a session or in assigning homework to deconstruct an impasse. When clients present as disengaged or provide limited verbal information, the therapist

must track and accommodate silence and limited conversation without formulating questions. Instead, he may employ countersystemic, contextual, displacing, system-restructuring, and reinforcing tasks, add or subtract systems, focus on the symptom itself, or modify the organization of the therapeutic members. Sculpting various family scenarios with family members may help clients gain insights into family structure and dynamics without using words. The use of such tasks enables the therapist to respect clients' communication dynamics (i.e., silence, disengagement) without demanding information or communications clients are unable or unwilling to provide.

The Shake-UP of the Case Scenario: In the above case scenario, the therapist could have created a safe session environment and promoted client trust by simply acknowledging how difficult it must be for family members to speak about their concerns. He may then have asked all family members to remain silent for ten minutes and concentrate on their immediate feelings. In turn, he could have invited each family member to draw a picture that expressed the feelings s/he had experienced during this period. The therapist may have also joined the family by creating a drawing of his feelings. By adopting these relatively simple techniques, the therapist may have achieved a shift from the role of the Journalist to the professional therapeutic role of the Angel; one that provided opportunities to communicate empathy, share emotional responses nonverbally, and reduce the probability of client resistance.

The Reflection: In order to determine if the Journalist is your preferred professional therapeutic role in a therapeutic environment, it may be useful to examine:

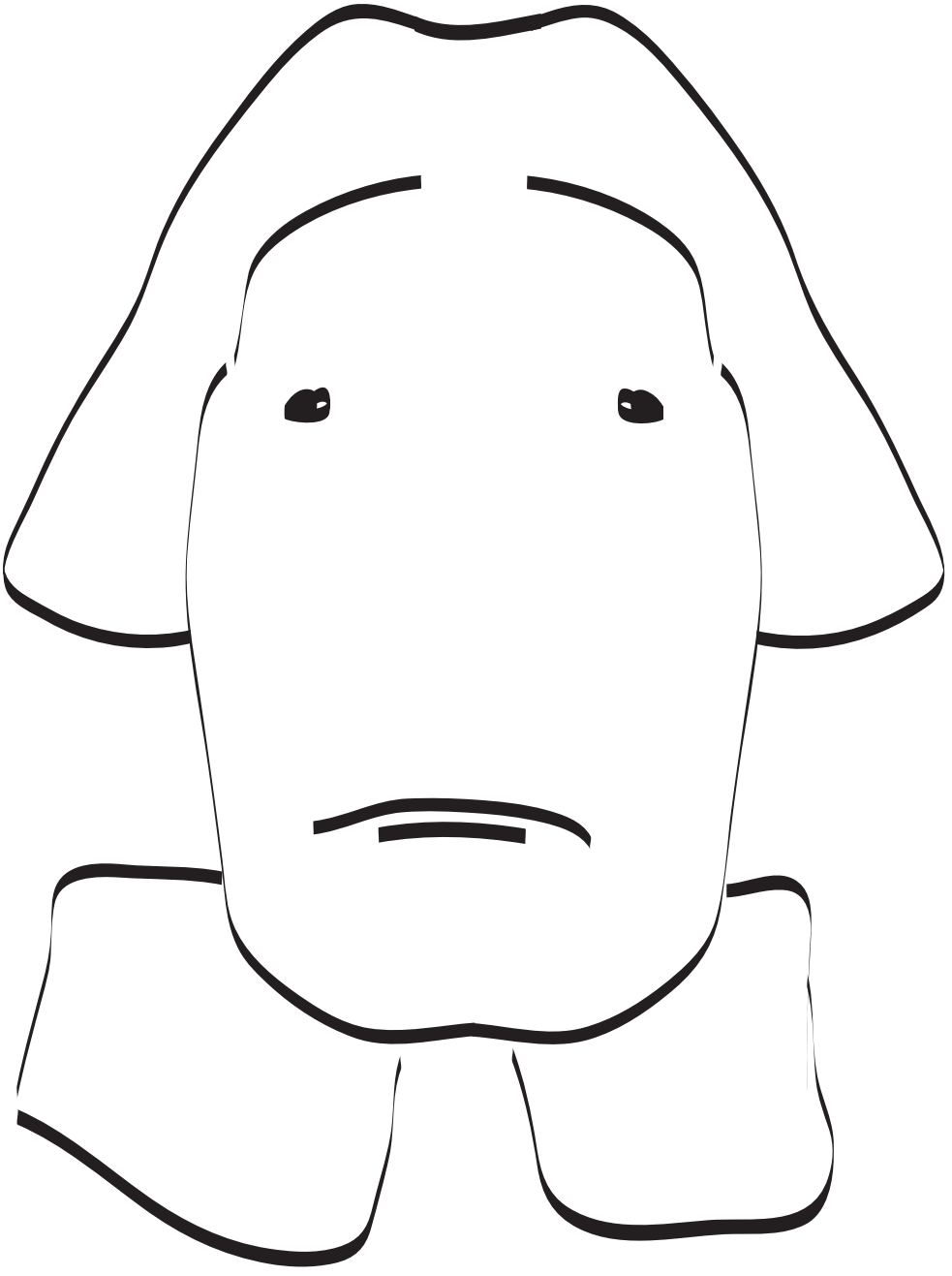
Family Genogram: Did you regularly ask questions of other family members in order to understand their perspectives or thoughts? Did you work to quickly analyze information while others spoke?

Social Circles: Did you ask many questions of friends in order to help them understand their problems? If you were actively engaged in social clubs, did you create opportunities for discussion so that information could be analyzed and issues be resolved?

School Experience: Were you the student who regularly asked questions in an attempt to analyze events that occurred in the classroom, at recess, and in relationships?

Therapeutic Style: Do you regularly ask questions and probe for information from clients? Do you provide space for clients to share their stories? Do you find yourself saying, "I wonder about… " and request more information from clients when tensions rise or clients express strong emotions?

The Judge



"Watch out!" Here comes the gavel and a decision is imparted to clients, "You are right; you are wrong!" One party leaves the session angry and in tears while the other smiles knowing that s/he have joined in a coalition with the Judge. The professional therapeutic role of the Judge is often activated when clients enter therapy presenting opposing positions in a conflict. The Judge has a tendency to make decisions and place a value on presenting behaviors (e.g. good, bad). The Judge typically displays effective listening, communication, analytical and problem-solving skills. He presents as highly ethical, trustworthy, patient, hardworking, and detail-oriented. The Judge often demands respect from clients, who demonstrate such respect by not questioning the Judge's decisions. The defining elements of this professional therapeutic role are to listen carefully to opposing sides presented by clients, render a verdict as to who is right or wrong in the situation and make a determination as to how the clients should act or not act. The judge tries to be honest but relies on his personal value system to make final judgement. Information gathered from members of the therapeutic system is used to help the Judge render fair and sound judgments. The primary unspoken message to the clients is that you you need me to decide what is right or wrong and how to live your life in a more righteous way.

The Positive Use of the Role: The professional therapeutic role of the Judge is positively enacted with clients who present situations in which one or more family members are demonstrating severe or abusive behaviors. In these situations the Judge may need to quickly gather information and render an opinion about the best response to the abusive situation in order to insure the safety of all family members. Within sessions, the primary role of the Judge is to create a safe therapeutic environment for all to be heard prior to rendering an opinion. The Judge must be cognizant of the fact that once he renders a decision, therapy may end abruptly as some clients may perceive that a coalition has developed between the therapist and other family members. However, in situations involving compelling evidence of potential harm to clients, the Judge is legally obligated to make judgments designed to insure the welfare of all family members. After client safety has been secured, the Judge may explore dynamics that support the presenting symptomology, including relevant family history, relationship issues, as well as antecedents and consequences of the abusive behavior.

The Seduction-Impasse Contributing: The Judge is seduced into action by two primary types of clients: those who quarrel frequently and present opposing opinions

regarding family dynamics and those in the process of a separation or divorce who seek an ally in presenting their case in court proceedings. Upon entering the therapist's office, such clients will often examine the therapist's diploma in order to discern his educational credentials. For these clients, the therapist's legitimate use of the title, "Doctor," is critically important. Session members may subtly or actively work to entice a therapeutic allegiance to their perspective on issues. In such conflictual circumstances, some therapists may feel out of control and quickly adopt the professional therapeutic role of the Judge in an attempt to alleviate personal anxiety and session tensions.

Clients often demand the Judge to provide a quick fix for presenting symptoms. Because of the Judge's educational achievements and clinical expertise, clients seldom question his opinions. Nor does the Judge use negotiation or mediation techniques with conflicted family members. He listens to presenting arguments (while often disregarding nonverbal interactions and communications), offers value-laden feedback (e.g., "you are right; you are wrong") regarding clients' behaviors, and renders judgments about required changes in clients' behaviors and interactions in order to resolve presenting concerns.

The Impasse: The Judge rarely encourages communication or negotiation among quarreling members in the therapy session. Instead, he encourages clients to direct communications to him in an attempt to gather facts for later use in rendering a decision. In this process, he collects basic information, often lacking sufficient breadth, about the development of the problem. When this process has been completed, the Judge renders an opinion, often based on incomplete information, with the goal of putting a halt to incessant quarreling. In this process one or more clients in the therapeutic session commonly feels slighted and perceives that a coalition between the Judge and other family members has been created. By failing to encourage communication and negotiation skills among family members, the Judge becomes stuck and a therapeutic impasse often results. In such circumstances, clients often terminate therapy having experienced no systemic change or problem resolution.

Case Scenario: Shanna and Brett present different sides to parenting their very active seven-year-old son. They quarrel frequently in the session over who is the better parent and disparage each other in front of their son. The couple presents their parenting styles to the therapist in an attempt to seduce him into selecting the better parenting technique. Shanna reports her belief that their seven-year-old son should be able to stay up until 11:00 pm each night to play video games. Brett disagrees with Shanna's comment and states his opinion that their son should be in bed by 9:00 p.m. Shanna begins to interrupt Brett when the therapist asks Shanna

to remain silent until he requests that she speak. Visibly annoyed with the therapist's comment, Shanna crosses her arms and legs and turns away from him.
The therapist continues to gather information from Brett, who claims that their son is sleeping in school. Shanna demands the floor and states that teachers have never reported this behavior and requests that the therapist phone the teachers to see that she is right. Brett goes on to say that he often punishes their son by taking away access to his video games. Shanna states that Brett's behavior is both unfair and abusive. The therapist asks additional questions regarding Brett and Shanna's parenting styles while listening intensely, but directing all conversation back to himself. After hearing what he believes to be all relevant sides of the argument, the therapist selects Brett's parenting style over Shanna's. Shanna is stunned by the therapist's feedback and becomes despondent. The family and therapist become stuck as parental quarrels continue and Shanna feels increasingly alienated by the actions of the Judge. After two more sessions, Shanna announces that she is terminating therapy.

The Risk: Perhaps the greatest risk for the Judge is "become more human" in the session by allowing clients to interact with each other. A therapist who functions in the professional therapeutic role of the Judge role tends to remain aloof and detached from clients. The Judge needs to put away his gavel and be willing to explore presenting problems and opposing sides from a holistic contextual viewpoint. Therapists who present themselves predominately as Judges are commonly insecure in their ability to maintain control of the session when tension, anger and strong opposing views are presented. Such therapists must learn to incorporate effective questioning and interviewing techniques that promote client examinations of interactional patterns, hidden dynamics that maintain symptoms, and family of origin issues.

The Alternative Intervention Style-Impasse Busting: There is a number of therapeutic professional roles that the Judge can utilize to deconstruct a face-to-face impasse with clients. Assuming the role of the Mediator may help the therapist to shift from making value judgments to promoting family communications and negotiations. Encouraging such changes in interactional style enables family members to understand and become more responsive to the others' points of view. Through mediation, family members may learn to manage conflicts, reduce quarreling and develop more effective communication skills.

Adopting the role of the Detective creates opportunities for the therapist to follow clues to reveal contextual environments that maintain presenting concerns. Switching to the role of the Construction Worker enables the therapist maintains control of the session by blocking erroneous information that fuels client arguments. Assuming the role of the Referee also provides for greater session control

as the therapist decides who speaks to whom and when. In addition, the Referee is empowered to monitor and manage clients' tones of voice and volume levels in order to help clients manage strong emotions while communicating important information. Taking on the role of the Teacher permits the therapist to teach clients new interactional patterns that can be practiced via role-plays and assigned homework. Perhaps the most useful therapeutic professional roles for adoption by the Judge are the Archaeologist and the Journalist. Working in these roles allows the therapist to pose questions designed to expose critical details of clients' family of origin that may reveal hidden dynamics of systemic dysfunction.

Techniques: The Judge may employ a variety of techniques or tasks within a session or as homework assignments to deconstruct a therapeutic impasse. When working with clients who present with strong opposing perspectives, the therapist may employ role-playing to help clients practice respectful ways of listening and responding to each other. The role-playing technique would be especially useful for teaching negotiation skills. While disassembling and de-emphazing differences among clients may help to reduce tensions between clients, developing implicit conflict in the session may provide insights into client disagreements. At other times the therapist may need to block transactional patterns that are maintaining the presenting symptom(s). The therapist may further employ tasks of attack or alliance in order to "see the dance" that impedes interactional styles and use this information to change a rigid structural system. The therapist can assign homework tasks that deal with practicing negotiation skills between clients. In adopting these techniques, the therapist typically plays an active role as interactional patterns are constructed, reinforced or reorganized between and among clients.

The Shake-UP of the Case Scenario: In the above case scenario, the Judge asked Shanna to stay and shifted into the professional therapeutic role of the Journalist. He eventually asked Brett and Shanna to share the story of their childhood and what it was like to grow up with their parents. The husband shared that his parents were fair, but enforced specific ground rules related to bed times, curfews and his choice of games or activities. Brett said that he was happy with the way he was raised, stated that his parents were fair and that he never felt constricted by their rules or guidelines. Shanna reported that her parents, especially her mother, were very strict and that she "hated" every minute living in her parent's house. She said that she could barely "do anything" and that her parents would often dictate acceptable activities. She indicated that she was not allowed to go to school dances or partake in school activities. She reported leaving her parents' home when she was eighteen and said that she "never looked back." She said that, as a child, she swore that she would not

"do to her children, what her parents had done to her". As Shanna shared her story, it became evident that she believed that setting rules or guidelines would cause her son to "hate" her and leave. By providing opportunities for Brett and Shanna to discuss their family of origin experiences, the basis for their conflict became evident. The Journalist suggested that he and the parents meet alone to explore ways to more effectively co-parent, co-discipline and build trust in order to help their son learn to respect and love both of them.

The Journalist shared that he would help them (in the role professional therapeutic role of the Referee) learn to negotiate and come to an agreement on a variety of parenting and family issues, including life-style, child-rearing, money, sex, values, and gender role differences.

In retrospect, the Judge initially failed to acquire sufficient information to determine why Brett and Shanna had adopted such different parenting styles. His value judgments had only served to intensify their parenting conflicts and alienate Shanna. When the therapist shifted into the professional therapeutic role of the Journalist, information gleaned from the clients' stories of childhood experiences enabled him to understanding their conflict. This insight allowed the therapist to shift once again into the professional therapeutic role of Referee, which enabled him to teach communication and negotiation skills that resulted in permanent systemic change.

The Reflection-In order to determine if the Judge is your preferred professional therapeutic role in a therapeutic environment, it would be helpful to explore your:

Family Genogram: Did you often listen to family members and then present a decision regarding how each member should act in a certain situation?

Social Circles: When with friends, did you tell them who was right or wrong when a disagreement emerged? If you were actively engaged in social clubs, were the person listening to all options and then rendering a decision as to the proper course of action?

School Experience: On group assignments, did you assume responsibility for making decisions regarding how assigned projects or tasks would be completed, especially if classmates had different ideas?

Therapeutic Style: Do you find yourself listening to opposing sides and then directing clients how they should respond in various situations? Do you often find yourself saying, "After carefully considering both sides of this issue, I believe that you should…"

The Mediator

"After listening to both of you, I think that you should consider going to the beach as John suggested and then drive home through the mountains as Abbie suggested. In that way, both will have your preferences at least partially met." The Mediator therapist presents as a non-biased negotiator for everyone involved in the therapeutic session. He relies primarily on problem-solving skills to help opposing parties achieve solutions. The Mediator adopts a neutral position in the session and explains each client's position with the hope that this knowledge will lead to a mutually agreeable problem resolution. The Mediator attends to and accurately interprets clients' body language while modeling negotiation techniques, active listening, and conflict resolution techniques.

Each client in the session offers his/her position on a presenting issue or dynamic. The Mediator then reframes this information from a positive perspective with the goal of insuring that each client's expectations are at least partially met. No one in the therapy session leaves unhappy. Through this process all clients are granted opportunities to express personal positions on the presenting concern and family tensions are consequently reduced. Clients provide a great deal of information, which is taken at face value by the Mediator. He does not analyze this information, but uses it only to help clients understand each other's desires. The primary unspoken message is to solve your problems you need to negotiate and compromise and I can teach you how.

The Positive Use of the Role: The professional therapeutic role of the Mediator is useful with most clients. This role is positively enacted with clients who quarrel other over rules, expectations, or life preferences. The Mediator role is particularly useful at the onset of therapy when quarreling is common and when working with families with adolescent children, where clients often present with unresolved conflicts. In this latter circumstance, the primary value of the Mediator role lies in the therapist's ability to reduce family tensions and model negotiation skills. By so doing, he creates opportunities for clients to more calmly discuss presenting issues (e.g., parental expectations, rules around the adolescent's freedom).

The Seduction-Impasse Contributing: The Mediator is seduced into action by clients who quarrel frequently in the session and who are unable take others' perspectives. Such clients frequently present with poor insight, linear thinking, a focus on meeting personal desires, and inabilities to negotiate solutions to common personal

or family problems. As clients are unable to reach agreements on presenting concerns, they look to the Mediator to make decisions for them. The Mediator responds to the amalgam of client quarrels, unresolved conflicts and learned helplessness by listening carefully to all client perspectives and making a decision designed to meet all client needs. In the process, he fails to challenge dysfunctional client interactional dynamics or to teach negotiation skills, reinforces clients' perceived inabilities to make effective decisions, and contributes to a therapeutic impasse.

The Impasse: Because the Mediator fails to teach decision-making, negotiation, or conflict resolution skills, clients' communication and interaction patterns do not change. Through the therapeutic process, some clients may experience temporary reductions in family tensions, but they fail to learn how to resolve their own problems. As a result, clients become highly dependent on the therapist, who assumes responsibilities for making clients' decisions. Although some clients may experience a fleeting sense of relief and contentment with this arrangement, it is short lasting. While the Mediator works actively to gather client information and dispense satisfactory solutions, he becomes exhausted by the demands of his role, the failures of his clients to resolve their problems, and the sense of being stuck as family dynamics remain unchanged. The lack of therapeutic progress promotes increasing client dependency on the therapist to make important decisions and the continuation of a dysfunctional therapeutic relationship that holds little promise for meaningful client change.

The Case Scenario: The Smith family has begun to think about retirement and is exploring various living situations. Mr. Smith would like to live in a condominium because all of the yard work would be completed through the condominium association. Mrs. Smith would like to remain in their family home, as she is happy with the area and proximity of the shopping mall. Although the Smiths have often discussed retirement plans and desires, they recently stopped listening to each other and began to argue, sometimes intensely. Mrs. Smith has become so distressed by these arguments that she is considering a divorce. At her husband's suggestion, she reluctantly agreed to enter therapy in order to resolve their differences. Mrs. Smith stated that, having been married for over forty years she "owed" him this favor.

Conflict over this issue was apparent in the first session as the Smiths began to argue as soon as the word "retirement" was mentioned. The Mediator (intern) therapist suggested that the Smiths contact a realtor who might help them locate a condo or townhouse close to the area in which they now live. The Smiths were very happy with this suggestion and wondered why they had not come up with the idea themselves. In a quick turn of events, the Smiths began to discuss restaurants where

they might eat lunch. Mrs. Smith stated her desire for a salad and said that the Salad Café would be a good place to eat. Mr. Smith indicated his desire for a roast Beef Sandwich and commented that the Salad Café did not serve sandwiches. The couple began to argue. Mrs. Smith said she was very tired of doing everything her husband's way, while Mr. Smith laughed loudly and said, "Since when?" The Mediator quickly suggested they go to Mr. Sandwich because this restaurant serves both salads and sandwiches. Again, the couple agreed and stated their surprise for not coming up with the idea.

Therapy continues in this manner for many sessions. Mr. and Mrs. Smith fail to negotiate solutions to problems and the Mediator does not teach negotiation skills. During this process, Mr. and Mrs. Smith start phoning the Mediator daily when they have problems. The Mediator eventually communicates his displeasure at receiving such calls even as Mrs. Smith cries and Mr. Smith informs the Mediator that he "is at the end of his rope." The Mediator realizes that the Smiths have become overly dependent on his solutions and that therapy has failed to provide them with the skills necessary to resolve their own problems. He further recognizes the therapeutic impasse and the need to change his professional therapeutic role.

The Risk: In order to move out of the professional therapeutic role of the Mediator a therapist must increase his comfort levels when client tensions rise. The biggest risk for the Mediator is to take a less active role in the session, allow client differences to surface, and permit clients to negotiate solutions to their problems without interjecting a compromise. Therapists who consistently present themselves in the Mediator role are generally insecure in their ability to maintain control of the session when clients demonstrate tension, disagreement, or conflicted positions on important issues. The Mediator must learn to model and teach negotiation techniques rather than make decisions for clients. He must direct clients to listen to each other, take alternative perspectives on the problem, reflect the desires and wishes of other family members, and demonstrate flexibility in thought and action in order to negotiate a solution acceptable to all. The Mediator must also demonstrate curiosity regarding family of origin values, cultures, negotiation habits, and traits that exacerbate presenting concerns. By assuming less responsibility for resolving client problems, teaching and practicing negotiation skills, and creating realistic expectations for clients to make decisions that lead to problem resolution, the Mediator is able to shift into more functional roles designed to promote lasting systemic change.

The Alternative Intervention Style-Impasse Busting: There is a number of therapeutic professional roles that Mediators can utilize to deconstruct a face-to-face impasse with a clients. Shifting to the role of the Teacher enables the therapist to

educate clients about dynamics that maintain chronic disagreements, decision-making strategies, negotiation techniques, dependency issues, and problem resolution skills. The therapist can model negotiation skills and then involve clients in role plays to practice and refine emerging abilities. The Teacher may also assign homework for family members to practice negotiation skills in their home environment. By integrating such teaching strategies, the therapist promotes client self-responsibility, enhances client self-efficacy, and cultivates clients' attempts to practice skills that hold the promise of producing lasting changes in the family system.

Adopting the role of the Detective enables the therapist to follow clues that may provide insights into dynamics that maintain clients' unwillingness to make decisions. Shifting to the role of the Construction Worker allows the therapist maintain control of the session by blocking erroneous information that may fuel client conflicts and arguments. Assuming the role of the Referee also provides opportunities for the therapist to maintain session control by deciding who speaks to whom, when, and for how long. Adopting the Referee role also permits the therapist to monitor and manage each client's tone of voice and volume level in an effort to avoid verbal assaults.

Perhaps the most useful professional therapeutic roles for the Mediator to adopt are the Archaeologist and the Journalist. In these roles the therapist may ask questions that reveal important details of each client's childhood experiences related to parental communication and conflict resolution styles, decision-making and negotiation skills, and child rearing practices. Knowledge of such family of origin experiences may help both clients and the therapist to understand and modify dynamics that maintain current dysfunctional behaviors.

The Techniques: The Mediator may employ a variety of therapeutic tasks or techniques within a session or as homework assignments to de-construct a therapeutic impasse**.** Assigning homework provides opportunities for clients to practice negotiation skills outside of the therapy session. Encouraging family members to participate in role-plays during sessions may nurture respectful ways of listening and responding to other family members and would be especially useful for teaching negotiation skills.

The therapist may exaggerate client differences or alter the affect around presenting concerns in order to gain insights into the dynamics of client conflicts. Conversely, he may use disassembling and de-emphazing differences techniques to reduce client tensions. At other times the therapist may block transactional patterns that maintain clients' unwillingness to negotiate. By skillfully employing a combination of techniques, the therapist can construct, reinforce, or reorganize client

interactional patterns in ways to reduce quarreling, improve decision-making and negotiating skills, reduce dependence on the therapist, and promote confidence in abilities to resolve personal and family problems.

The Shake-UP of the Case Scenario: In the above case scenario and following several sessions, the Mediator (intern psychologist) consulted with his supervisor. The supervisor suggested that the intern shift into the professional therapeutic role of the Archaeologist with the goal of understanding dynamics underlying the couple's inability to negotiate a retirement plan. The supervisor suggested that the intern begin by using a timeline to help Mr. and Mrs. Smith discuss views on how their lives will be changed in retirement. The supervisor instructed the intern to require both clients to discuss their hopes, dreams, and views of the future so that their unspoken "fears" related to retirement could be revealed and openly addressed. The supervisor told the intern that he would eventually need to risk shifting into the professional therapeutic role of the Journalist. In this role, he would ask each client to share the story of his/her childhood and how each dealt with disappointment he/she did not get his/her way in the family of origin. Clients' responses would reveal the basis for resistance to each partner's retirement ideas and feelings of being in a "no-win" situation. In the Journalist role, the therapist would also pose questions designed to reveal details of parental dynamics in each client's family of origin regarding communication patterns, decision-making skills, conflict resolution abilities, and a variety of other issues. The supervisor reinforced the fact that clients' family of origin experiences may serve to maintain current inabilities to communicate effectively or to negotiate a mutually satisfactory retirement plan. The supervisor added that shifting to the Journalist role would help the therapist to discern dynamics that prevented Mr. and Mrs. Smith from developing more compromising attitudes.

In retrospect, the intern's adoption of the Mediator role resulted in client failures to understand their fears regarding retirement or to develop a mutually acceptable retirement plan. During the therapeutic process, clients became highly dependent on the intern and did not learn communication and negotiation skills. Adoption of the professional therapeutic roles of the Journalist and the Archaeologist were recommended to help the couple gain insight into family dynamics that support current dysfunctional patterns, decrease dependence, and learn new communication, decision-making and negotiation skills.

The Reflection: In order to determine if the Mediator is your preferred professional therapeutic role in a therapeutic environment; it may be useful to examine:

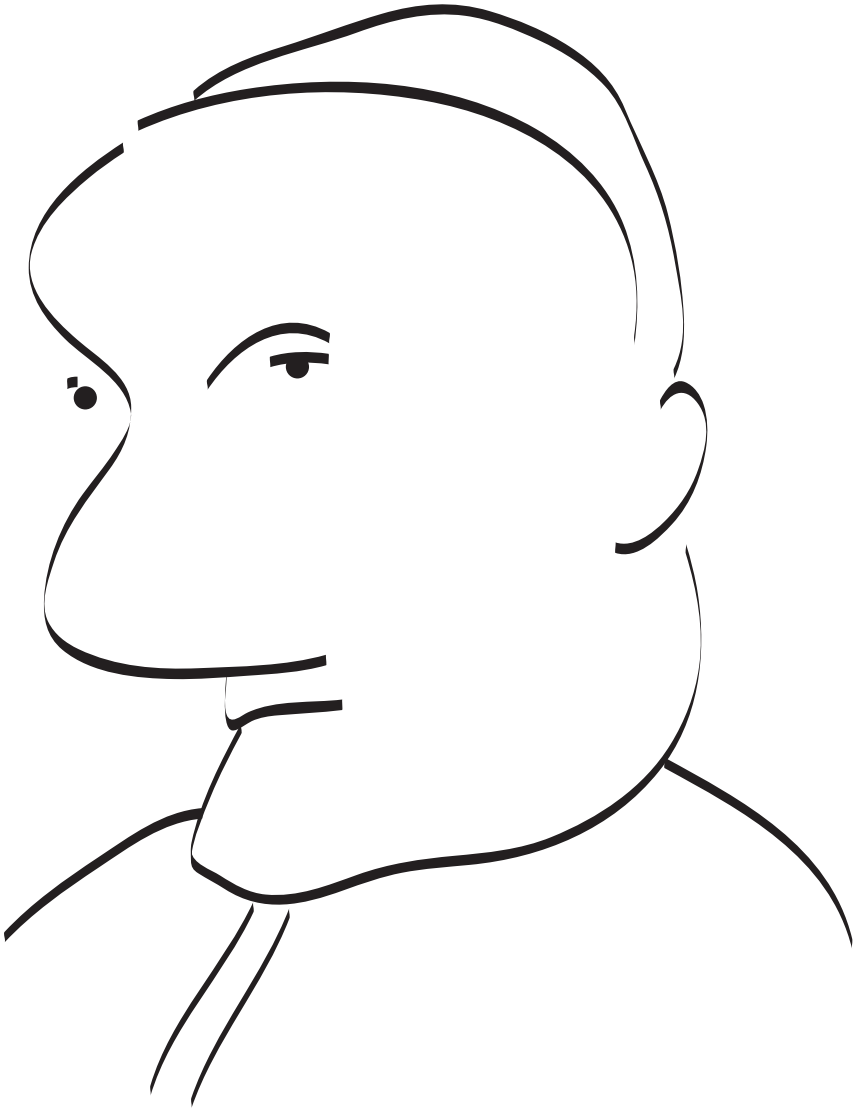
Family Genogram: When your family members argued, did you try to mediate by creating a solution that would make everyone happy?

Social Circles: When friends argued, did you try to make everyone happy by attempting to blend everyone's wishes and desires? If you were actively engaged in social clubs, did you listen to all sides of an issue and make decisions designed to please everyone?

School Experience: Were you the student who listened to classmates argue about the best way to complete a group assignment and then present solutions that would please all?

Therapeutic Style: When working with families or groups, are you comfortable listening to each client's desires or wishes and then suggesting a solution that will please all clients? Do you often find yourself saying, "Wait… they can do this and then try this..."

The Preacher



"Home schooling? I believe that is a very irresponsible choice for parents who truly care about their children. Children need socialization, interactions with others and, by the way, do you possess the education credentials required to home school your children?" The preferred professional therapeutic role of the Preacher stems from a belief that clients need to receive direction in life based on established moral or ethical principles. Consequently, such therapists commonly "preach" to clients.

The Preacher demonstrates strong communication and organizational skills, which he uses to motivate clients to want to change their behaviors. The Preacher holds strong ethical, political, and religious values, which serve to impart a particular way of thinking. The Preacher presents to clients as dependable, yet passionate about projecting strong religious, ethical and moral beliefs onto clients for their own good. The Preacher typically advises couples to respond to problems or dilemmas in a dichotomous, either-or manner. The therapeutic session is based on the Preacher's belief system. Client values contrary to those of the therapist are often marginalized or discounted in therapy sessions. Throughout the therapeutic process, the Preacher remains blissfully unaware of his overbearing impositions.

The Preacher typically collects only limited information about presenting concerns and does not attend to interactional communication styles between or among clients. The Preacher is more interested in how well session members are listening to him and are encouraged to direct all conversation towards him. The primary unspoken message to the clients is that you need to listen to me and adopt my values and beliefs because I know what is best.

The Positive Use of the Role: The professional therapeutic role of the Preacher is positively enacted when clients appear to lack a moral direction in responding to an important family matter or when family role models are needed, but are unavailable. The Preacher role can be used productively to provide clients with support and guidance, particularly in stressful or emergent situations. In such circumstances, the Preacher may be able to help clients identify courses of action consistent with well-established values and ethical frameworks. However, the manner in which he communicates such information must not impose the Preacher's personal values, promote dichotomous client thinking or insult clients' cherished beliefs or values.

The Preacher role may be particularly useful in working with immigrants, whose values and belief systems are different than those of society-at-large. The Preacher may help immigrant clients to understand dominant cultural beliefs, values, and

social norms in an effort to smooth their transition to a new country with different rules and expectations. In providing such support, the therapist must carefully bridge differences between the client's homeland's culture and that of the adopted homeland in order to promote adjustment, while communicating respect for both cultures. Productive use of the Preacher role may help clients to achieve psychological stability and balance in a new culture and result in improved levels of functioning at home, school, and within the larger society.

The Seduction-Impasse Contributing: The Preacher is seduced into action by clients who present with strong ethical beliefs and value systems. Such clients may "shop around" until they find a therapist whose beliefs and values are compatible with their own. When clients present with an identified patient (IP) who opposes the prevailing family value system, the therapist and other family members often try to "convince" the IP to adopt values and beliefs consistent with the dominant system. In this process, the Preacher gathers only minimal information before launching into a "sermon" designed to help clients and the IP understand the best way to resolve the problem. By preaching answers and solutions to clients, tensions and disagreements among family members are held in check. Clients in such family systems rarely stay in therapy for long. This is because an unspoken goal for (perhaps) the majority of family members is to re-route the IP back into to the system by adopting the values and beliefs of hierarchical parents, whose behavior is frequently reinforced by the therapist.

The Impasse: The Preacher rarely understands the presenting symptom because he selectively focuses on client beliefs and values. He is unconsciously seduced into action by family members' ethics, values and belief system, which he attempts to impose on the IP. In this process, the Preacher finds himself caught in a double bind as clients claim to seek change in the family system, but work only to secure reinforcement of their dominant values. Faced with an untenable situation, the Preacher may become aloof or demonstrate disinterest in client concerns.

The Preacher recognizes only family members who share his values and belief systems and, for a time, clients are pleased by his efforts. Because his energies are focused on declaring "correct" solutions to family problems, the Preacher fails to observe or consider the influence of clients' non-verbal interactions on problem maintenance. Over time, clients become disenchanted with therapy for a variety of reasons: they are not interested in genuine change, but only the therapist's proclamation that the IP adopt their beliefs, values, and perspectives; they commonly demonstrate dichotomous thinking on issues that require more complex cognitive responses; and, the Preacher never addresses client interactions and family dynamics

that maintain the presenting problem. As a consequence, clients rarely make clinical progress and everyone in the therapeutic system becomes stuck. The impasse that results is exacerbated when the IP rejects the therapist's values, along with those of other family members, and acts out even more aggressively against the "system." Both clients and the therapist recognize his inability to promote meaningful systemic change and therapy is usually terminated.

The Case Scenario: Amelia is the 18-year-old daughter of a foreign diplomat. Demonstrations of gracious attitudes and proper behaviors are very important to her parents. Both parents, but especially her father, have declared that Amelia only engage in behavior conducive to their family's "social status" when in the presence of others. Weary of what she refers to as her parents' "hypocrisy," Amelia begins to act out. She is rude to her parents and their house guests, has several parts of her body pierced and wears gaudy eyebrow rings and navel studs, purchases a facial tattoo and refuses to attend social gatherings in her parents' home. Amelia's anger intensifies when a new therapist, the fourth that her parents have arranged in the past year, encourages her to attend sessions and participate actively.

With Amelia and her parents present, the therapist begins the first session by imparting to Amelia the importance of complying with her parents' wishes. Amelia responds by crossing her arms and staring at the floor. She refuses to make eye contact or respond to questions. Amelia demonstrates these behaviors throughout the following two sessions as the therapist proclaims the critical importance of deferring to parental demands. As the family and therapist reach an impasse, Amelia refuses to attend additional sessions and her parents report being at their "wits end." Disappointed by the therapist's inability to change their daughter, the parents terminate therapy and seek a more convincing therapist who can impart their values and the appropriate social graces to their "troubled" daughter.

The Risk: In order to move out of the professional therapeutic role of the Preacher, a therapist must be skilled in accommodating, listening, reinforcing and tracking clients' belief and value systems without judgment. The Preacher's greatest challenge is to demonstrate openness to and acceptance of other philosophical views. Such acceptance is particularly important when treating immigrants and clients from varying cultural backgrounds. The Preacher must work to supplant linear and dichotomous thinking with a more complex and holistic cognitive style characterized by openness to divergent ideas, beliefs, values, and cultural norms. He must be approachable yet keenly aware of nonverbal interactions between and among clients.

Perhaps of greatest importance, the Preacher must work to understand the overt and covert intentions of the IP's behavior and how such actions may be a disguised

attempt to help other dysfunctional family members (i.e., IP actions that require police interventions into a system characterized by spousal abuse that would only be revealed through his acting out and the subsequent involvement of law enforcement personnel). The Preacher must understand that the IP will often go to extreme measures (unconsciously) to alter what he views as a very rigid and unhealthy family system.

Therapists whose predominant presentation is in the Preacher role usually exhibit a rigid cognitive style characterized by a need to order the world in a manner consistent with personal beliefs and values. Unable to consider alternative perspectives, such therapists often fear and degrade client expressions of contrary points of view. If he is to help clients, the Preacher must create a safe therapeutic environment by listening to clients' views and concerns without bias or preconceived convictions. By slowing the therapeutic process, listening openly, and communicating emphatically, the therapist is poised to understand how family of origin values, cultural beliefs, negotiation habits, and traits undergird and maintain clients' strong philosophical values and convictions. If successful, the therapist may create a therapeutic atmosphere characterized by acceptance of multiple perspectives, understanding and respect for differences, and opportunities for meaningful systemic change.

The Alternative Intervention Style-Impasse Busting: There is a number of professional therapeutic roles that Preachers can utilize to deconstruct a face-to-face impasse with clients. Assuming the role of the Journalist provides opportunities to gather relevant information about the presenting problem and how clients have organized themselves around it. Shifting into the role of the Archaeologist creates openings for the Preacher to investigate clients' family histories regarding the development and maintenance of strongly held philosophical values and beliefs. Adopting the role of the Savior allows the Preacher to intervene, connect and demonstrate commitments to work with family members on a deeper personal level. Shifting into the Bird Watcher role creates opportunities for the therapist to slow the session pace, listen attentively, and observe nonverbal interactions between and among clients. Operating in the professional therapeutic role of the Clown permits the therapist to interject humor as he works to shatter rigidly held values and beliefs. Assuming the role of the Judge enables the therapist to pass clinical judgment on the wisdom of adopting and maintaining rigid patterns of thought and behavior while adopting the Construction Worker role creates opportunities to block value-laden communications that inhibit client growth.

The Techniques: The Preacher may employ a variety of therapeutic tasks or techniques within a session or as homework assignments to deconstruct the impasse. He

may use tracking, accommodating, and mimesis techniques during initial sessions to understand clients' values and beliefs. He may add or subtract systems to break the gridlock created by client adherence to strongly held beliefs or values and to restructure the symptom. By exaggerating the presenting symptom, the therapist may reduce the need for the symptom and decrease client reactivity. The Preacher may reorganize clients around the presenting symptom with the goal of introducing more flexibility into the family's structure. He may block clients' transactional patterns designed to shut down an IP down during the session or use metaphorical tasks to reduce defensiveness as clients discuss strongly held values and beliefs. When one member of the system is opposing the philosophical views of others the therapist may employ tasks of alliance so that the IP does not feel isolated. Finally, the therapist may use contextual tasks to modify clients' rigid responses to the IP's communications. Through humor, the therapist can redefine the presented problems and behaviors in a powerful way helping to remove the tensions which are present among clients.

The Shake-UP of the Case Scenario: In the case scenario above, the family had terminated therapy with a fourth therapist in a one-year period and sought out yet another. During the first session with the new (fifth) therapist, the parents shared their perceptions of the previous psychologists and why therapy had failed. They reported that Amelia did not want to be in therapy and said that if she did not change her behaviors, they would transfer her to a boarding school. As the parents spoke, the therapist observed and was intrigued by Amelia's strong nonverbal interactions. She looked angry and sat with her arms crossed, facing away from her parents. At that point, the Preacher took a risk. He assumed the professional therapeutic role of the Journalist and changed his focus from the parent's story to an exploration of Amelia's behaviors with the goal of understanding her perspective. At first, the parents objected to this change in the therapist's behavior; they made it clear to the therapist that they expected him to support the "rules" they had created for their daughter. The therapist calmly replied that it was very important for him to hear from Amelia.

He asked Amelia why she had refused to attend the last dinner party given by her parents. Amelia reported that she was not permitted to speak at these parties and that her parents had demanded that she sit at the table until all guests had finished eating (sometimes as long as 3 hours). She said that she did not mind helping her parents with their diplomatic duties, but that her mother had become so engrossed in supporting her father's career that she no longer had time for her only daughter. Amelia cried as she discussed earlier times when she and her mother would shop

and have lunch together. She said that she was afraid that her mother no longer loved her and that she had behaved badly in recent months in order to "hurt" her mother.

The Journalist then asked the mother to share her reaction to Amelia's statements. The mother said that she had no idea that she was so unavailable or that her daughter missed her. The Journalist then asked the mother to share a story about when she and her daughter would shop and have lunch together. The mother warmly related a story about how much she enjoyed her daughter's company and their fun-filled times together. When the mother began to cry, Amelia reached out to hug her for the first time in over a year. The Journalist then asked Amelia and her mother to go shopping and to lunch during the next week and to report the outcome when they next meet. During the following session, Amelia and her mother smiled and laughed a great deal as they shared details of their recent outing. While smiling at her mother, Amelia reported that she had even helped "mom" to set the table for a "diplomatic" dinner during the previous week.

In retrospect, the Preacher failed to understand that by acting out, Amelia was working feverishly to communicate her unhappiness about the perceived loss of her mother's affection in the context of family rules. When the Preacher endorsed her parents' views, Amelia shut down and an impasse developed. By shifting into the professional therapeutic role of the Journalist, the therapist risked alienating the parents. However, he was willing to take this risk because he understood the need to explore Amelia's needs as expressed by her behaviors during the previous year. These behaviors suggested that something was very wrong in the family and that she was desperately seeking her parent's attention. The Journalist offered Amelia the opportunity to "voice" her fears and anger on a platform that forced her parents to listen. As her parents listened, Amelia's mother suddenly recognized the emotional gap that had developed in their relationship; that her daughter was missing her and that she missed her daughter. By prescribing homework designed to reconnect mother and daughter in an activity they both enjoyed, the Journalist cemented an emotional connection that led to symptom reduction and greater family harmony.

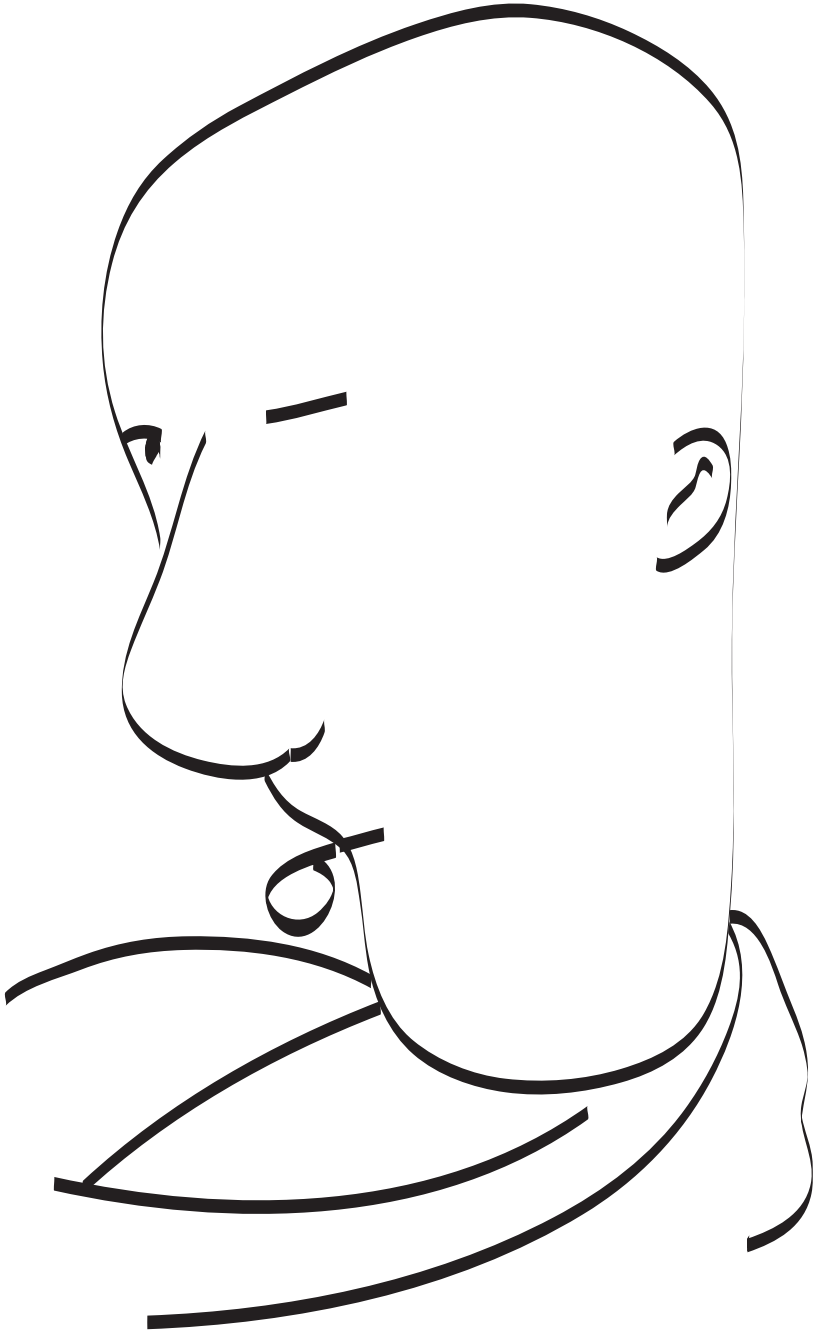
The Reflection: In order to determine if the Preacher is your preferred professional therapeutic role in a therapeutic environment, it may be useful to examine:

> **Family Genogram:** As a child, were you quick to share your opinions and become angry if other family members did not endorse yours?
> **Social Circles:** Were you eager to share your opinions, then become angry and ignore friends if they did not support your views? If you were actively engaged in social clubs, did you insist that things be done your way? If others in your circle chose a different way, did you respond by getting angry?

School Experience: When assigned to work on a group project, were you the student who decided what was to be done, how it was to be done, and by whom? When completing a project were you careful to consider other's ideas?

Therapeutic Style: As a therapist, are you tolerant of clients' views or do you find yourself imposing personal beliefs and values? Do you often find yourself saying, "Clients need to do things this way…after all it is in their best interests?

The Referee



The whistle blows, action stops, and clients freeze…all focus their attention and eyes on the therapist. The Referee is about to make a decision regarding the rules of engagement within the session. The Referee therapist controls clients's progress, looks for violations of interactional rules, regulates session communications and blocks certain clients from participating in a session when necessary. By using high levels of session control, the Referee unintentionally stifles the natural rhythms of client communications and interactions to the point that clients do not speak or act without the Referee's permission.

The Referee operates from a rigid set of rules that apply to all clients. The Referee assumes responsibility for determining who speaks to whom, when, for how long and in what way. Through this process, client tensions may be moderated as all members in the session get a turn to speak. However, information imparted by clients is often so truncated that the therapist is unable to conduct a meaningful analysis. Referees have the ability to handle very stressful therapeutic situations and are not hesitant to structure client communications in ways that may result in client expressions of anger. The primary unspoken message to the clients is that you need me to create and implement clear rules in this family in order to keep the peace.

The Positive Use of the Role: The professional therapeutic role of the Referee can be useful with clients who lack personal discipline, family rules, or communication boundaries, and in circumstances where family members take actions in complete disregard of others' needs. In most cases, clients have difficulty setting limits or boundaries regarding appropriate family behaviors. In such cases, the therapist may consider adopting the Referee role at the onset of therapy in order to present a new hierarchical structure in the family setting for these clients. Effective role implementation holds the promise of producing a more structured family reorganization characterized by meaningful connections among members.

In this process, the Referee decides who speaks to whom and when during the session. This session structure creates opportunities for members of the therapeutic system to listen to each other. Families with adolescents or children may benefit most from working with a Referee therapist, whose command of session structure can create conditions that reduce tensions and provide opportunities for family members to display mutual respect. In cases where parents engage in chronic bickering, it is common for children to "protect" their parents from talking about differences by acting out in order to divert attention from their parents' anger. By virtue of his

ability to restructure family rules and communications, the Referee is positioned to halt such diversions so that parental conflicts, particularly those related to child rearing practices, can be discussed and analyzed.

The Seduction-Impasses Contributing: The Referee is seduced into action by enmeshed clients who have a tendency to speak for each other. These clients bring to the session a sense of confusion and chaotic interactions as family members, especially children, consistently interrupt parental communications. When instructed by the therapist to not interrupt, clients often use deep sighs or exaggerated body movements to create nonverbal interruptions. Through this process, clients seduce the therapist into monitoring and controlling their communications and behaviors to the point that he is unable to attend to critical information about client dynamics that maintains presenting symptoms. In such circumstances, clients may also present as highly anxious, which further seduces the therapist into addressing clients' emotional states. With so many energies devoted to monitoring and controlling client and session dynamics, the Referee is unable to conduct meaningful explorations of family dynamics, which contributes to the impasse.

The Impasse: Chaotic family dynamics presented by many clients are often intensified by their conflicting messages that serve to double bind the Referee. For example, clients may communicate desires for the therapist to monitor their dysfunctional interactions and help them achieve higher levels of autonomy within the family system while simultaneously challenging or even sabotaging his efforts. In light of his preferred role tasks, the Referee may demonstrate success in reducing clients' anxiety levels, but fail to modify interactional dynamics. The unconscious message to clients is that they are unable to resolve their own issues without the environmental control and structure provided by the Referee.

Although clients may leave the therapy session feeling temporarily contented, the Referee often feels exhausted from his intensive efforts to control the structure and flow of the session. Neither individual nor systemic change occurs because family dynamics that maintain symptoms are never resolved and clients ultimately fail to exhibit effective communication skills and appropriate family boundaries outside of the therapy session. In the absence of change, clients' anxiety levels gradually increase and clients become highly dependent on the Referee, confident that they need someone outside of the system to control them. After weeks of intensive but ineffective therapy, the Referee and clients recognize that they are "spinning their wheels" with regard to presenting problems. Frustrated and angry about their lack of progress, clients frequently terminate therapy prematurely.

The Case Scenario: The Conrad family presents as a highly enmeshed system concerned about their daughter's choice of a boyfriend. The mother supports the oldest daughter's choice while the father and youngest sister oppose. Strong coalitions are apparent between the mother and the oldest daughter and the father and the youngest daughter. When the mother speaks, the youngest daughter makes gasping sounds and the father turns his body away from her. When the oldest daughter begins to yell at her sister, the father steps in to protect her. In response, the mother and oldest daughter look at each other and both roll their eyes. The Referee attempts to intervene but the family goes on with their interactions as if the Referee does not exist. The Referee becomes exasperated as family members attempt to speak for each other and as both daughters consistently interrupt their parents' communications.

In an effort to create session structure, the Referee introduces a communication plan that specifies the circumstances in which each family member is permitted to discuss an issue, the amount of time provided for this discussion, and prescribes silence by other family members during such discussions. As he implements this plan, both daughters interrupt their parents' conversation by sighing deeply and shaking their heads. The Referee responds by stringently monitoring and restructuring members' communications and interactions. As a consequence, he is unable to explore presenting issues or the dynamics that support them. After several sessions characterized by the same therapist efforts and family interactions, the Conrad family and the Referee reach an impasse as relationship conflicts, dysfunctional communications, and enmeshed behavior continue both within and outside therapy sessions.

The oldest daughter continues her relationship with her boyfriend despite her father's strong objections and dismay. When the therapist directs parents to discuss differences in parenting styles, both daughters demonstrate highly disruptive behaviors that divert attention from this critical issue. In the absence of problem improvement or change in the family system, the Mr. Conrad angrily blames the Referee and terminates therapy.

The Risk: In order to shift out of the professional therapeutic role of the Referee, a therapist must demonstrate abilities to carefully observe and analyze family dynamics that create an enmeshed structural organization. The Referee must change techniques from those designed to control clients and the session environment to others that provide for accommodation of client dynamics. The Referee must listen carefully for clues that may explain system rigidity and quickly analyze family interactions that obfuscate unmet needs. The Referee must further understand how the IP's behaviors may represent efforts to protect other family members.

The Referee often becomes stuck by his attempt to order his clients' world and fails to create a safe therapeutic environment where natural client interactions may be observed and analyzed. If he is to successfully shift out of this preferred role, he must demonstrate curiosity about family of origin values, norms, parenting styles, negotiation habits, and traits that support the enmeshed system and maintain coalitions. By adopting such strategies, the Referee may reduce reliance for both himself and family members on rigid roles that support counterproductive outcomes.

The Alternative Intervention Style-Impasses Busting-There is a number of therapeutic professional roles that Referees can utilize to deconstruct a face-to-face impasse with a client. Assuming the role of the Teacher creates opportunities to educate clients about the benefits of adopting more effective communication patterns. For example, the Teacher can explain the importance of listening to and acknowledging other's opinions, thereby creating relationships characterized by respect and mutual trust. He may use in-session, role-play scenarios to provide clients with opportunities to practice active listening skills. Shifting into the professional therapeutic role of the Bird Watcher enables the therapist to carefully observe family interactions, identify coalitions, and determine how they work to support hidden family dynamics.

Adopting the Journalist role may facilitate a change in session tempo and generate changes in communication dynamics by creating opportunities for clients to "share their stories." By asking open-ended questions of each client, the Journalist demonstrates a sincere interest in all members and insures that each will have an opportunity to be heard. The Journalist may find questions designed to reveal information about the history and development of family coalitions to be particularly useful. Shifting into the Mediator role enables the therapist to model effective communication and negotiation skills, while assuming the Clown role empowers the therapist to interject levity into family systems characterized by strong negative emotions, weighty seriousness, or an absence of hope. Assuming the role of the Archaeologist allows the therapist to explore hidden agendas, family of origin enmeshment behaviors, and dynamics of coalition development and maintenance in clients' families of origin.

The Techniques: The Referee may employ a variety of therapeutic tasks or techniques within a session or as homework assignments to deconstruct the impasse. System restructuring tasks may be employed to bring a sense of order into an enmeshed system. In order to be able to create a greater focus on presenting symptoms and underlying causes, the therapist may choose to add or subtract systems (i.e., in the case scenario above, the therapist may have decided to meet alone with the parents

or siblings and/or invite the boyfriend into the session). He may alter reactions to nonverbal behaviors in the session, thereby altering the affect and response of others to the disruptive behaviors. The therapist may work to disassemble rigid coalitions by creating new coalitions in the system (i.e., changing mother-oldest daughter coalition to a sibling coalition) or employ metaphorical tasks to implode rigid client structures. The Referee may also use genograms to help both family members and him to understand how the cultures of both parents and their family of origin cultures may have influenced the development and maintenance of presenting problems.

The Shake-UP of the Case Scenario: In the case scenario above, the therapist adopted the professional therapeutic role of the Mediator. He asked the parents to sit directly across from each other with each "aligned" daughter sitting directly behind, but facing away from the parent. The Mediator then directed the parents to discuss both their concerns about the daughter's boyfriend and positive aspects of the relationship. During this discussion, the therapist instructed the daughters to remain silent while recording their reactions on a sheet of paper.

As a homework assignment, the Mediator instructed the girls to collaboratively create two lists: a list of parental concerns about the boyfriend and list of positive elements of the relationship identified by their parents during the session. He further directed the daughters to present these lists to their parents at the next session. The Mediator employed this homework assignment to foster positive sibling communications, promote a unity of purpose, and create a sibling subsystem that would encourage improved parental communication. While reading their jointly developed lists in the following session, the daughters exhibited no reactive behaviors and remained silent while their parents discussed their reactions to listed items.

At that point, the therapist shifted into the professional therapeutic roles of the Journalist and the Archaeologist. In these roles he explored each parent's culture in their family of origin related to values, beliefs, and roles. Following this discussion, the parents described similarities and differences between the boyfriend's culture and those of their families of origin. Through this process, the parents came to understand that differences in their daughters' values and beliefs (and the choice of a boyfriend) were mirrored in differences in their family of origin cultures.

The therapist then assigned another homework task to the daughters. He instructed each to write down significant aspects of each parent's culture as they had communicated during the session. He told the daughters to bring these documents to the following session, at which time they would discuss their reports and also present to their parent's a description of an ideal family culture. During the next session, the daughters provided both their report and a jointly developed description of an ideal

family culture. The therapist then encouraged the parents to respond to this description. During the discussion that followed, the therapist asked the parents to discuss their perceptions of the boyfriend in relation to the ideal family culture described by the daughters. Following several more sessions and with informed consent, the therapist invited the boyfriend to participate in a family session. During this session, family members and the boyfriend discussed a variety of issues that ranged from their respective families of origin to personal beliefs and values. In this process, the boyfriend and all family members developed more accurate understandings of each other's beliefs, values, and relationships.

In retrospect, the parents' views of the boyfriend were based on unique family of origin values and beliefs. The boyfriend's culture appeared to mirror that of the mother's family of origin, while the father's vastly different values had created misunderstanding and distrust. By shifting into three alternative professional therapeutic roles, the therapist was able to help clients improve communication dynamics, enhance their understanding of conflicting positions, and examine elements of an ideal family culture.

The Reflection: In order to determine if the Referee is your preferred professional therapeutic role in a therapeutic environment, it may be useful to examine the following areas in the development of your "living culture":

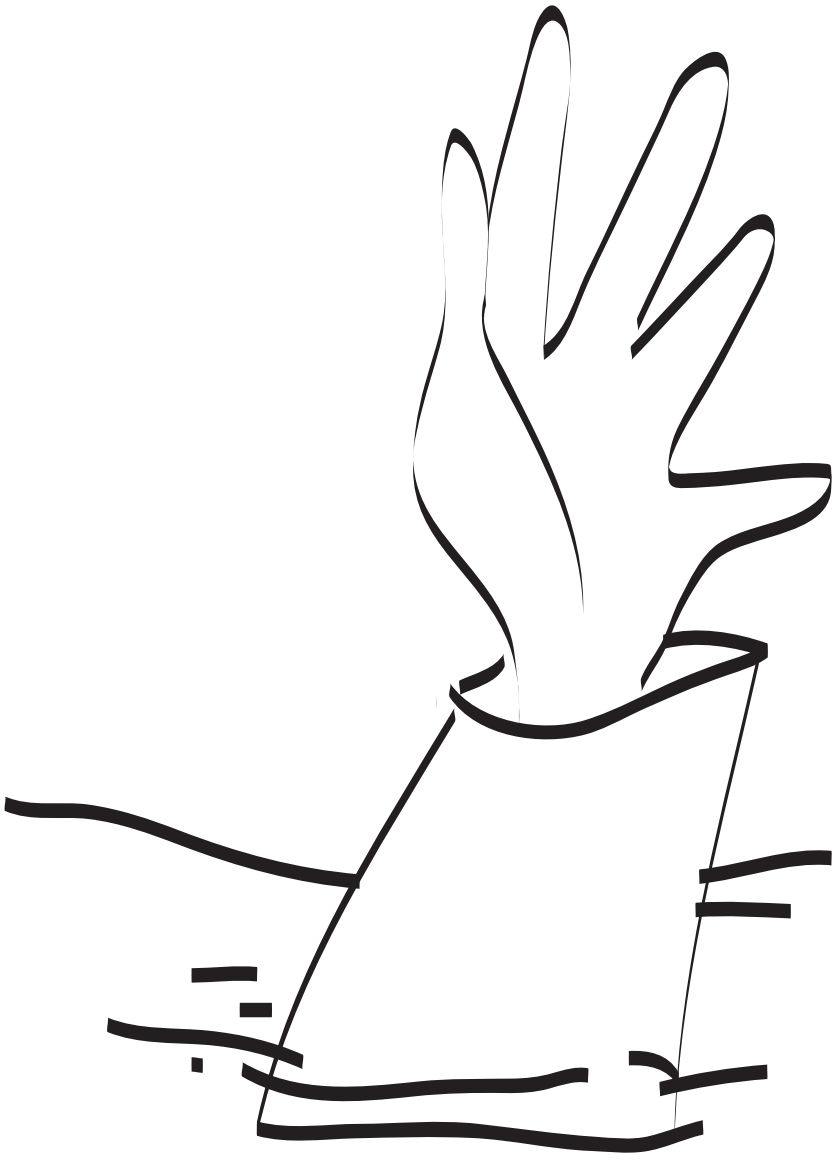
Family Genogram: When family members argued did you intervene by trying to control everyone's reactions? Did you often feel exhausted after a family argument or when involved in a situation where disagreements had occurred?

Social Circles: When friends fought, did you "step in" and try to stop the arguing? If you were actively engaged in social clubs, did you attempt to allay others' social fears by controlling communications (e.g., determining who spoke to whom) when things appeared chaotic?

School Experience: Did you take charge of group assignments by determining who would complete specific tasks and establish deadlines for completion? If other students spoke at once, did you try to regulate interactions?

Therapeutic Style: Are you uncomfortable with enmeshed systems? Do you sometimes feel compelled to determine who speaks to whom, when and for how long? Do you say to yourself, "Do something, Do something" when constant interruptions and dysfunctional nonverbal behaviors result in rising client tensions?

The Sailor



"Mayday! Mayday! The boat is sinking and I am drowning. Help!" A variety of session dynamics may cause novice therapists to experience uncertainty, confusion, anxiety, and fear. For example, it is common for new therapists to feel overwhelmed when clients present voluminous information, particularly when multiple family members offer simultaneous presentations. In this circumstance, the Sailor therapist may feel panic and not know how to proceed, what to say, or what to do in order to reduce his anxiety and fear. In an attempt to hide his emotions and create a professional persona, the Sailor may employ "cookbook" approaches and responses with clients. At completion of the session, he may consult textbooks or Internet web sites for ideas on how to respond to session dynamics with the goals of appearing more competent and reducing anxiety in future sessions.

When the therapist adopts the professional therapeutic role of the Sailor, he frequently conducts inadequate assessments of client problems, provides little feedback regarding client concerns, and becomes incapacitated by his fears. Consequently, he becomes silent, appears to be lost, and communicates an air of professional incompetence. The primary unspoken message conveyed to the clients is that they are really in trouble because even the therapist is at a loss of what to do next. In the absence of a clinical direction, all members of the therapeutic system become confused and a chaotic session environment results.

The Positive Use of the Role: Despite its obvious limitations, this professional therapeutic role may be useful with clients who are disengaged. The role is best enacted with clients who come to therapy with a sense of who they are and where they want to go; they are self-motivated and require little direction. Adopting the professional therapeutic role of the Sailor may also be an effective for working with clients who display an inappropriate absence of family tensions or minimal interactions with each other. By simply observing session dynamics, it may be possible for the Sailor to introduce an element of tension that promotes client interactions.

Conducting research between sessions enables the Sailor to acquire updated knowledge and state-of-the-art skills for working with complex client issues such as medical conditions, pharmacological therapies, and disability issues. Research findings may also help the Sailor to understand family members' resistance or "stuckness" around a presenting concern and develop effective treatment interventions.

The Seduction-Impasse Contributing: The Sailor is seduced into action by clients who seek couple or family therapy. The Sailor often has limited experience with families and performs most effectively in conducting individual sessions. The presence of multiple clients in the session may trigger anxiety that quickly erodes and supplants professional self-confidence. Repeated sessions characterized by episodes of anxiety may degrade the therapist's self-confidence to the point that he becomes convinced of his inability to work effectively with couples or families. As a consequence, when working with family members who regularly interrupt each other and speak out of turn, the Sailor may freeze and fail to acknowledge client communications. As clients vicariously sense the therapist's panic, helplessness and hopelessness, they may experience similar emotions. All of these conditions contribute to an impasse. The unconscious message to clients is that their problems are so serious that they endanger the integrity of their family system.

The Impasse: By virtue of his emotional distress and behaviors, the Sailor actually creates tension and conflict within the session. The therapist's silence often results in escalating clients' vulnerabilities, which may lead some to blame each other for the therapist's helplessness. The Sailor is neither able to assess presenting problems nor help clients work toward their resolution. The family and therapist become stuck because as family members quickly recognize the therapist's inability to assist them. In such circumstances, clients commonly terminate after one or two sessions.

The Case Scenario: Jena and John come to the therapist's office with their newborn baby in tow. They begin the session by expressing concerns about their lack of emotional intimacy and emerging differences in their views about childrearing since the birth of their daughter. The Sailor asks John to elaborate on these concerns. While John is speaking, the Sailor turns his body away from Jena, who is holding the baby, and focuses exclusively on him. Speaking for ten minutes without pause, John describes his many disappointments with his wife. The Sailor begins to squirm in her seat as she does not wish to appear rude by interrupting John. After chronicling his disappointments for another ten minutes, Jena becomes annoyed and attempts to interrupt. In response, the Sailor does not change her position or acknowledge Jena.

The baby begins to cry and John yells at Jena for being a bad mother. This surprises the therapist, but she does not say word. Jena then begins to cry and the baby's crying grows louder. John becomes more upset and he and Jena begin to yell at each other. As the baby settles down, Jena is visibly angry. She swears at John, says that he is a horrible father and that she wants out of the marriage…now! They turn to the Sailor for assistance, only to find her sitting silently in her chair and staring vacantly at the floor.

Overwhelmed and incapacitated, the Sailor does nothing to halt the verbal barrages and angry retorts. Unable to cope with these circumstances, Jena picks up the baby and leaves the session in tears. John apologizes for his wife's rudeness and says, "Now you see what I live with!" The Sailor acknowledges that a problem exists but says nothing more. John leaves the session in anger, after blaming the therapist for losing control and making his wife upset. No further appointments are made.

The Risk: In order to move out of the professional therapeutic role of the Sailor, the therapist must be willing to adopt new roles and actively practice a wide range of clinical techniques during therapy sessions. These are extreme risks for the Sailor, whose repertoire of professional therapeutic roles and techniques may be limited by inexperience or inadequate supervision. However, the Sailor may remedy such deficiencies by consulting regularly with more experienced therapists and by requesting immediate supervision (the one-way mirror technique may prove to be particularly useful).

More specifically, the Sailor must learn to: (a) develop an effective interviewing style by using questions productively; (b) block assaultive client interactions in order to create necessary session structure and productive communication patterns; (c) engage clients in thoughtful explorations of presenting concerns; (d) adopt various professional therapeutic roles and therapeutic techniques consistent with clients' problem presentations; and (e) be more confident in his abilities to help clients. In addition, the Sailor must develop competence in attending to the needs expressed by multiple clients (particularly through their use of body language) and in responding to interactions and tensions around the presenting symptom.

The Alternative Intervention Style-Impasse Contributing: There is a number of professional therapeutic roles that the Sailor can utilize to deconstruct a face-to-face impasse with clients. Shifting into the professional therapeutic role of the Doctor enables the therapist to communicate with expertise on research-based topics that are critical to client care. Implementing the roles of the Detective, the Journalist, and the Archaeologist allow the therapist to take an active role in collecting essential information around presenting concerns. Adopting the Construction Worker role provides opportunities to block client communications when the therapist feels overwhelmed with excessive information. Assuming the Referee role provides for greater session control in determining client communication patterns in order to insure that all clients have opportunities to voice concerns and perspectives. For clients in crisis, shifting into the Firefighter role creates options for prioritizing client needs and creating a therapeutic starting point.

The Techniques: The Sailor may employ a variety of therapeutic tasks or techniques within a session or as homework assignments to deconstruct an impasse. If a family presents with multiple subsystems that obfuscate important client dynamics, the therapist may subtract members to discern more focused perspectives. The therapist may also manipulate the presenting symptom by exaggerating concerns, de-emphasizing the symptom, changing the affect around the symptom, making a new symptom or relabeling the symptom. The therapist may employ countersystemic tasks to expose homeostasis in the family system and system-restructuring tasks to create structural changes. The Sailor may further opt to accommodate family members, disassemble clients' organizational structure by highlighting individual differences, help family members become cognizant of nonverbal communications, develop implicit conflict within the therapeutic session, or reinforce tasks in order to create more effective session and client communication structures.

The Shake-UP of the Case Scenario: In the case scenario above, the novice Sailor therapist felt overwhelmed and confused about John and Jena's angry session departure. She consulted with her supervisor and recounted session details. The supervisor reassured her that it is common for beginning therapists to feel overwhelmed when presented with voluminous client information.

The supervisor then told the Sailor that she should have risked shifting into the role of the Construction Worker. In this role, the supervisor said that she should have stopped John from speaking after five minutes, then turned immediately to Jena to request her perspectives on the problem. The supervisor explained that this action would have helped to diminish John's dominance in the relationship and provided the necessary structure for both parents to be heard. The supervisor further indicated that Jena needed protection and that by shifting into the Construction Worker role, she would have been able to better manage John's scapegoating behavior.

The supervisor suggested that should the therapist feel overwhelmed in future sessions, she may benefit by taking a deep breath, sitting back (both physically and emotionally), and shifting into the Bird Watcher role. The supervisor explained that by adopting this professional therapeutic role, the therapist would be better positioned to observe the effects of clients' communications on other family members. The supervisor strongly recommended that the therapist periodically adopt the professional therapeutic role of the Journalist, which would provide opportunities to ask questions productively, engage clients in meaningful dialogue, and develop a personal interviewing style. The supervisor's final recommendation was that the therapist works to develop her observational and attending skills during sessions

by listening carefully to clients' communications while also focusing on clients' nonverbal interactions.

In retrospect, Jena felt scapegoated and unprotected by the Sailor therapist. When this novice therapist failed to protect her from John's assaultive diatribe and did respond to her verbal or nonverbal communications, she angrily left the therapy session. The husband then scapegoated the therapist by blaming her for the session failure.

The Reflection: In order to determine if the Sailor is your preferred professional therapeutic role in a therapeutic environment, it may be useful to examine:

Family Genogram: When tensions rose among family members, did you say nothing? hide in your room? suffer in silence?

Social Circles: When friends argued, did you withdraw and remain silent? If you were actively engaged in social clubs, were you intimidated by members' emotional expressions and respond by saying nothing?

School Experience: Did you rarely speak in class? If other students complained, did you sit quietly, listen and say nothing?

Therapeutic Style: Do you find yourself lost in the session, wishing it was over? Do you often find yourself saying, "I'm drowning and have no place to go for help!"

The Savior

"Help me! Help me!" cries the victim. "I am helpless and they are attacking me again". To the victim's aid the Savior runs, "I am here! I am here! And, will save you. I promise." The professional therapeutic role of the Savior is perhaps the one that most helping professionals tend to amplify. It is also the role into which they can most easily be seduced. Like a hero, the therapist conceptualizes his role as one primarily concerned with saving his victimized clients, particularly those who are the victims of scapegoating.

The Savior has a strong tendency, indeed a need, to work with clients who desperately require help and he will often assist them to the point of making personal sacrifices. As a result the Savior is highly active in sessions, works very hard, and takes responsibility for clients' successes. The Savior believes that saving people is a noble and practical endeavor and so assumes responsibility for curing all. The primary unconscious message to family members is that whatever is needed to save this family, I will do.

The Savior responds to clients' tensions and conflicts by trying to subdue them. Discussions are often directed toward the therapist and symptoms are only addressed while the Savior believes that victims feel comfortable or until victims are "saved." The Savior halts discussions related to presenting concerns if he perceives that session communications cause victim distress. The Savior believes that the cruel nature of human existence causes most clients to be victimized and to externalize their problems. However, he does not challenge clients regarding their roles within the prescribed problems.

The Positive Use of the Role: The professional therapeutic role of the Savior may be positively enacted with abused clients and those who require extra support or guidance, such as elderly clients. In such circumstances, the therapist may need to intervene quickly to insure client safety. The Savior role may also be useful when working with refugees and immigrants, whose knowledge of the host culture and public resources or services may be limited. In this case, the Savior must not be seduced into personally contacting agencies for immigrant clients, but guide them into self-directed behavior. The therapist should only take responsibility for contacting agencies when he believes that agency staff will profit from knowledge of identified client interventions and when he can facilitate client/agency staff communications.

The Seduction-Impasse Contributing: The Savior is seduced into action by three primary types of clients: (a) those who come to therapy with an identified scapegoat(s); (b) immigrants who have experienced problems (i.e., discrimination, maltreatment) working to obtain benefits or services in governmental or agency bureaucracies; and, (c) elderly clients who present as helpless by virtue of limited family or agency supports.

Clients who present an identified patient (IP) in the therapy session often appear to be emotionally taxed as they launch verbal attacks or attempt to scapegoat the family member. An immigrant client who reports unfair treatment by government/agency staff may appear as helpless and extremely fearful of being returned to her native land (a potential reality) if she demonstrates assertive behavior regarding her rights. Elderly clients often present as tearful, helpless, and without a support system; they are alone. In such circumstances, the Savior is seduced into action in order to save the victim from vicious family members and heartless governmental agencies that intentionally deprive such clients of required resources. Consequently, the Savior may spend hours or days trying to reach a government agent or writing letters on the immigrant's behalf. Information gleaned during therapy sessions is used only to monitor the status of the IP, the immigrant's progress in obtaining needed benefits or the elderly client's state of affairs regarding access to services and family support.

However, the "realities" presented by such clients and perceived by the Savior may be misleading. All too frequently, emotionally distraught family members truly want to be heard and the IP to be cured, despite their inappropriate verbal volleys. Despite the real difficulties immigrants often experience in their encounters with government bureaucracies, some may be unwilling to accept personal responsibilities for problems they create through negligence or failures to meet agency deadlines. Such clients may only want the therapist to do their work for them. Although many elderly clients clearly require assistance and support, some may use the therapeutic process as a venue for securing the services of an empathic, full-time caregiver. In such cases the Savior not only divests clients of opportunities to learn new skills and create bridges to required resources, but also contributes to a therapeutic impasse.

The Impasse: In his rush to aid clients, the Savior rarely collects sufficient information to accurately assess or understand the conflicted interactions between and within family members, the clients' systems, or between clients and external/government agencies. Consequently, underlying dynamics that maintain presenting symptoms are never revealed and responsibilities for problem maintenance and resolution are not explored. Through his knee-jerk reaction to "save" all family members, the therapist may inadvertently create a coalition with the "victim," further alienating

other family members. Similar problems result with immigrant and elderly clients as the Savior assumes too much responsibility for their problems; the therapist promotes client dependency and helplessness.

Clients and the therapist become stuck because the Savior's attempts to meet personal needs by saving his clients obscure his professional judgment, relationship boundaries, and good clinical practice. As a result, the therapist feels overwhelmed and disenfranchised by having assumed excessive responsibilities even as client problems remain unchanged and family members are even more helpless than at the start of therapy. In fact, clients will only remain in therapy and happy as long as the therapist does their work for them. If the therapist attempts to create a more productive therapeutic environment, clients may terminate prematurely. Consequently, the Savior comes to feel trapped in a system of his own making; clients never make clinical progress, become more dependent on the therapist, and never learn to take responsibility for their lives.

The Case Scenario: Pedro has entered the United States on a temporary visa. While in the U.S., he fathers a child that the mother does not want and plans to give it up for adoption. However, Pedro wants the child. In desperation, he contacts a therapist and makes a strong emotional plea for the therapist to help him so that he does not lose his child. Because Pedro is in the U.S. on a temporary visa, he is worried that if he contacts a government agency for assistance he will be deported.

In order to help Pedro, the Savior makes several phone calls to government agencies with the goal of preventing the adoption of his child. Even though the Savior is unfamiliar with U.S. immigration laws, he takes immediate action in order to "save" the father and the child from a life of separation. Pedro takes no action to help create his desired outcome. In sessions, he exhibits increasing levels of helplessness, thereby placing increasing responsibilities on the Savior to solve his problem. Over several weeks, Pedro appears to become more depressed, helpless and dependent. Pedro and the Savior eventually become stuck. The Savior determines that he is not in a position to help Pedro because he does not possess sufficient knowledge of either immigration or adoption laws. Through this process, Pedro fails to learn how his passivity and dependence have contributed to the problem and his feelings of helplessness turn into depression. Without having learned about his immigration options or child custody rights, Pedro' visa eventually expires and he is forced to leave the country without his child and feeling deeply depressed.

The Risk: In order to move out of the professional therapeutic role of the Savior, the therapist must learn to create objectivity in the session by conducting a comprehensive assessment of client problems, working with clients to develop and evaluate

treatment options, and promoting client responsibilities for taking actions required to meet identified goals. These are extremely risky behaviors for the Savior, who is more comfortable listening for clients' crises and saving them from their plight.

Through this process, the therapist must develop strategies to suppress reactive, "saving" impulses, reduce needs for session control and grow comfortable with accommodating client concerns. While exploring presenting concerns, he must gather sufficient information to illuminate dynamics of the client's learned helplessness, lack of assertiveness, and difficulties in taking action to resolve identified problems. He may partially achieve these goals by demonstrating curiosity with regard to the client's family of origin, values, cultural beliefs, negotiation habits, and personal traits. The Savior must learn to listen carefully, objectively, and with a "third ear" for client distortions as problems and concerns are presented. The Savior must further adopt a less active posture in therapy sessions, develop an interviewing style characterized by unconditional acceptance of the client, and demonstrate abilities to facilitate client decision-making without assuming client responsibilities for action.

The Alternative Intervention Style-Impasse Busting: There is a number of therapeutic professional roles that Saviors can utilize to deconstruct a face-to-face impasse with clients. Working in the professional therapeutic role of the Teacher creates opportunities to guide and educate clients into action and change. The primary reason for adopting the Teacher role is to create a safe therapeutic environment for sharing and exchanging knowledge that clients may use to assume greater responsibilities for behavioral change. Shifting into the professional therapeutic role of the Detective enables the therapist to discover and follow clues that may provide insights into clients' feelings of helplessness.

Adopting the role of the Secretary allows the therapist to record clients' histories, perceptions, and progress so that changes in the status of presenting problems can be shared with the clients over time. Assuming the professional therapeutic role of the Journalist enables the therapist to pose critical questions designed to facilitate understanding of client problems and promote development of functional behaviors. Shifting into the professional therapeutic role of the Archaeologist creates options to examine the influences of family of origin, cultural milieu and developmental patterns on perceptions of authority, assertiveness, passivity, and helplessness in a variety of social contexts. Adopting the professional therapeutic role of the Clown permits the therapist to interject humor into the session, which may enable clients to gain a new perspective on their situation and reduce intensity levels around the situation.

The Techniques: The Savior may employ a variety of therapeutic techniques or tasks within the session or as homework assignments to deconstruct the impasse. He may use role-playing techniques to provide clients with opportunities to practice newly learned assertive behaviors in a safe environment. The Savior may employ counter-systemic tasks to challenge client and system "stuckness" created by homeostasis. He may also help clients to reframe assertive behaviors in order to challenge rigid cognitive thinking. The therapist may utilize reinforcing tasks to promote and maintain client gains or prescribe tasks for completion on a weekly basis to help clients manage risks as they implement new behaviors. The therapist may also prescribe rules to determine a client's responses in a particular situation. It is often helpful for the Savior to re-label a symptom so that the need to "save" others is not so strong and clients begin to feel less desperate about their situations. In order to reduce his reactivity to clients' emotions, it is often helpful for the Savior to track clients' communications and focus on nonverbal communication patterns displayed within the therapeutic system. When working with families from different cultures, the therapist may find the use of a genogram with illustrations of clients' cultural backgrounds to be particularly effective.

The Shake-UP of the Case Scenario: In the case scenario above, the Savior assumed excessive responsibility in his attempts to help Pedro. By adopting the professional therapeutic role of the Teacher, the therapist helped Pedro to learn about a variety of resources and government agencies available to assist him. By requiring Pedro to pursue these resources and to contact agency staff, the Teacher helped Pedro to develop assertiveness skills and become less dependent. More importantly, these actions helped Pedro to understand his rights and responsibilities related to immigration and adoption policies, secure custodial rights to his child, and learn that he is the master of his own fate.

In retrospect, therapists operating in the Savior role can cause significant harm to clients despite their best intentions. By redressing personal needs for control and placing reasonable demands for self-sufficiency on clients, the therapist promotes client self-awareness, autonomy, responsibility, and efficacy.

The Reflection: In order to determine if the Savior is your preferred professional therapeutic role in a therapeutic environment, it may be useful to examine:

Family Genogram: In your family of origin, did you play the role of martyr and assume responsibility for everyone else's behavior?

Social Circles: When friends were hesitant to complete a task, did they rely on you to complete it for them? If you were actively engaged in social clubs, did you

assume responsibility for completing unfinished jobs when members failed to follow through?

School Experience: Did you assume primary responsibilities for completing group assignments and allow other students to take credit for your work? If other students complained about completing an assigned task, did you react by doing the work yourself?

Therapeutic Style: Are you quick to take on the responsibilities of your clients? Do hastily develop a treatment plan for which you will assume major responsibilities? Do you often find yourself saying, "I am overwhelmed, I am overwhelmed" when you assume responsibilities for client's behaviors?

The Secretary

Notebook in hand…pencil at the ready…clients speak and the therapist devotedly records the flood of ensuing communications. Dutiful in his role, the therapist says little but records a lot. The therapist who operates in the professional therapeutic role of the Secretary assumes an interpersonal posture of aloofness. He uses the tools of his trade, a notebook and pen, to anchor his detached relationship with clients. In this professional therapeutic role, the Secretary provides little feedback as he focuses energies on observing and recording family members' verbal and nonverbal communications and interactional styles. The Secretary is typically skilled in simultaneously completing a variety of session tasks (e.g. listening, recording, typing, writing, etc.) and works well under pressure. Because the Secretary does not openly respond to observed client conflicts, some clients may question his motives and as he simply observes and documents session dynamics. All communications are directed toward the therapist, who encourages clients to speak directly to him. By discouraging client interactions, the Secretary confines explorations of problems that brought clients to therapy or the dynamics that support them. Consequently, symptoms are only addressed on paper. The primary unconscious message to clients is that what you say or do is worth recording; but I will not take action to alter or change your behavior or concerns.

The Positive Use of the Role: The professional therapeutic role of the Secretary is perhaps most useful with enmeshed clients who may attempt to seduce the therapist into their tangled family system. In such circumstances, the therapist may intentionally use his notebook and pen as therapeutic tools to create psychological distance in the therapeutic relationship. This strategy may serve to moderate the seduction dynamic and promote appropriate professional boundaries.

The Seduction-Impasse Contributing: The Secretary is seduced into action by clients who come to therapy looking for a nonthreatening therapist, who is uncomfortable with conflict and unwilling to challenge client behaviors. Such clients typically want to be heard, but have no interest in changing interactional styles or resolving presenting problems. As clients observe the Secretary recording their comments and interactions, they may experience a temporary sense of self-importance and attempt to re-experience this emotion by repeating information to insure that the therapist has captured their vital words and ideas.

The Impasse: By virtue of his temperament and preferred professional therapeutic role, the Secretary does not permit clients' conflicted feelings or interactions to surface in therapy sessions. Although he may observe and record clients' communications and reactions, the Secretary does not use this information to develop hypotheses that may lead to productive explorations of dysfunctional family dynamics. By adopting this role, the Secretary unintentionally insures that dynamics that maintain presenting problems remain intact and that systemic change will not occur.

The therapeutic limitations imposed by the Secretary role contribute to an impasse. Although both the therapist and clients seem to be happy with work completed during therapeutic sessions, systemic change cannot occur. However, family members and the therapist eventually become stuck because information is only recorded and analyzed outside the session; little if any feedback is ever provided to the family. In these circumstances, clients typically choose one of two therapeutic courses. They remain in therapy because of the occasional feelings of self-importance it provides or they terminate the therapeutic process knowing that the therapist has failed to help them.

The Case Scenario: Eleven-year-old Cyndi has been experiencing anxiety attacks in school. As Cyndi and her parents enter the session, names are exchanged. The therapist then tells Cyndi's parents that information they provide about Cyndi's anxiety attacks is very important and that recording their statements will help him to remember key points. Both parents nod their heads to communicate their understanding.

As the parents provide a history of Cyndi's attacks, the therapist feverishly records their comments. After sharing information for several minutes, the parents suddenly turn to each other with expressions of anger. The father launces a verbal assault on his wife and charges that Cyndi's anxiety attacks are the result of her poor parenting. The mother turns away from father, but he does not stop his verbal barrage. The therapist does not intervene, but requests additional information from both parents. As the session continues, both parents direct their conversation to the therapist who says little, remains aloof, occasionally nods his head and continues to record information. In this process, the therapist fails to observe or record the parents' nonverbal interactions.

Suddenly, Cyndi exhibits symptoms of an anxiety attack. In response, the therapist only says, "interesting" and without looking up, continues to record notes. Nobody attends to Cyndi as her parents escalate their conflict in a process of mutual blaming. As the session draws to a close, the therapist states that it will be critical to collect additional information in future sessions. After several similar sessions, the family and therapist become stuck as parental conflicts do not subside and Cyndi's

anxiety attacks become more intense, especially at home. The parents eventually terminate therapy after having identified a new therapist and ask the original therapist's session notes be forwarded to her.

The Risk: In order to move out of the professional therapeutic role of the Secretary, the therapist must allow himself to be fully present (i.e., physically, psychologically, emotionally, relationally, spiritually) during the session as a caring human being and trust that his memory will retain key information. This is extremely risky behavior for the Secretary, who is comfortable with his aloof posture and reliance on session notes to document important client communications. The Secretary must work to create stronger relationships with clients by using accommodating and tracking techniques. In this process, he must collect enough information about clients' histories, verbal and nonverbal communication dynamics, and family conflicts to determine their influence on presenting problems. By adopting these strategies, the Secretary may create an interviewing style that permits client tensions around the symptom to emerge and which hold the key to problem resolution and lasting change.

The Alternative Intervention Style-Impasse Busting: There is a number of therapeutic professional roles that the Secretary can utilize to deconstruct a face-to-face impasse with clients. Adopting the professional therapeutic roles of the Angel or the Savior enables the therapist to present to clients in a more fully human and caring manner. Shifting into the Bird Watcher role allows the therapist to examine how interactional patterns among clients change when tensions build. (Note: The Bird Watcher and the Secretary roles share common characteristics. Therapists are strongly encouraged to understand similarities and differences in these professional therapeutic roles and to employ only relevant interventions during role shifts). Assuming the Clown role enables the therapist to introduce lightheartedness, levity, and laughter into sessions characterized by excessive tension or seriousness. Operating in the Clown role also creates opportunities for the therapist to present a sense of personal "aliveness" that may help clients to understand their problems in the context of "the big picture" of their lives. Shifting into the roles of the Detective, the Journalist or the Archaeologist allows the Secretary to determine appropriate information for discussion, analysis, and use to construct new ways of relating around presenting symptoms.

The Techniques: The Secretary may employ a variety of therapeutic techniques or tasks to deconstruct the impasse. In order to join with the clients, the Secretary may accommodate by accept their rules and type of communication that are presented within the therapeutic system. He may use countersystemic tasks to directly expose

system homeostasis or system-restructuring tasks to create structural changes within the family. The therapist may introduce implicit conflict into the session and then reinforce behaviors that enhance client communications. He may also displace a symptom from one client to another in order to shift tension and create less rigidity in the system. The use of humor will help to redefine and reframe the presented problems and behaviors in a way which will help to remove the tensions which are present among clients. When the clients present as very rigid the use of family sculptures and metaphorical tasks can help to produce insight for clients regarding their rigid state of communication. Each of these techniques is grounded in a set of sub-techniques and basic skills that include tracking, accommodating clients, promoting client awareness of nonverbal communications, and disassembling clients' organizational structure.

The Shake-UP of the Case Scenario - In the case scenario above, the therapist shifted into the professional therapeutic role of the Detective. In this role, he asked Cyndi if she would explain what she thought her mother meant when she looked angrily at her father. He also asked Cyndi's father to identify which of his wife's interactions were more useful in helping him to understand her true feelings: her angry facial expressions or her words.

The therapist also asked Cyndi to talk about things that worry her. After providing this information, the therapist asked Cyndi to demonstrate her worry by "having an anxiety attack" in the session. As she produced symptoms consistent with an anxiety attack, it became obvious to both the therapist and Cyndi's parents that she was capable of "faking" this event. Knowledge of her abilities to create an anxiety attack led to two outcomes for Cyndi's parents: 1) awareness that her anxiety attacks at home may not be genuine; and, 2) needs to understand family dynamics before an anxiety attack at home in order to determine if precursors motivate Cyndi's response.

As a homework assignment, the Detective instructed Cyndi to "fake" an anxiety attack at home when her parents argue. He asked Cyndi to insure that her parents observe her anxiety attack and to report their responses during the next session. The therapist further instructed Cyndi's parents to stop what they are doing, rush to Cyndi's side, and calm her during the attack. By using the paradoxical therapeutic technique of prescribing the symptom (anxiety attack), Cyndi's parents learned to meet their daughter's needs for attention. Through this process, the affect around the parent's arguing was also altered as they learned the negative impact of their arguments on Cyndi's health and well being.

In an alternative response to the same scenario, the Secretary adopted the professional therapeutic role of the Clown by mimicking (in a humorous way) the

parents' nonverbal communications and facial gestures. By understanding that the Clown's ludicrous behaviors reflected the absurdity of their actions, the parents felt compelled to act. With the therapist's help, they engaged in a thoughtful examination of their parenting philosophies and important differences in beliefs and values that supported each position. With continuing therapist support, the parents were able to develop and implement a mutually agreeable plan for rearing Cyndi in a way that fostered optimal growth. Noteworthy is the fact that three weeks after implementing their plan, Cyndi's anxiety attacks mysteriously ceased.

In retrospect, Cyndi's anxiety attacks were a plea for her parents to stop arguing and to provide her with much needed attention. By shifting into alternative professional therapeutic roles, the Secretary was able to help all family members understand dynamics that supported problem interactions and achieve meaningful and lasting change.

The Reflection: In order to determine if the Secretary is your preferred professional therapeutic role in a therapeutic environment, it may be useful to reflect on the following questions:

Family Genogram: Did you keep track of family members' perspectives on conflictual issues and remind them of their positions as they made important decisions?
Social Circles: When friends shared a wealth of information, did you keep a diary to make sure you remembered what they said? If you were actively engaged in social clubs, did you volunteer to take notes?
School Experience: Did you take copious class notes in order to remember information presented by the teacher? If other students complained about taking notes, did you provide a copy of your notes?
Therapeutic Style: Are you more likely to record notes during rather than after sessions? During sessions, do you sometimes say to yourself, "Slow down. I can't write that fast."

The Superman

"No longer am I just a man. I am Superman….you look at me as just a 'therapist'…but I know the difference between right and wrong… as I am Superman…" (Superman theme song lyrics, retrieved 2010). The Superman therapist has an unhealthy sense of responsibility, or the belief that clients lack the capacity to successfully resolve their own issues and therefore need someone to "save" them. The Superman knows everything and can be easily identified by the diplomas or certificates displayed in the therapy room. The Superman will be confident in abilities regardless of symptoms presented. The Superman is arrogant and does not listen to anyone. All communication is directed toward the Superman and clients must constantly praise him for the honor of working with him. The primary unconscious message to clients is, "You lack the intelligence of knowing how to handle yourself in any situations; therefore I will direct you and you will listen." In the movie, "What about Bob," the psychiatrist clearly displayed the professional therapeutic role of the Superman. The Superman has advice for all situations and the answers for all questions. Furthermore, the Superman frequently shares his experiences and engages in "name dropping" of all the important people he knows. Often the Superman therapist may have an inferiority complex and may emphasize educational accomplishments in an attempt to disguise personal limitations. The Superman assumes that he is superior when, in fact, he is not. This false sense of success is a defense mechanism to compensate for perceived inferiority, which too often results in alienating clients.

The Positive use of the Role: The Superman position is not effective with any client typology as it renders them helpless and lowers their self-esteem. This role is employed by therapists who feel insecure about themselves as a professional and who cannot acknowledge that they may be less than "perfect" in any area. This role is an unhealthy one for the Superman and his clients because it fosters client dependency.

The Seduction-Impasse Contributing: The Superman is seduced into action by clients who are very insecure and who demonstrate low self-esteem. Such clients want a therapist to guide and make decisions for them. They often come to therapy looking for a "father or mother" figure. These clients often place the Superman on a pedestal and the Superman enjoys the acknowledgement. Very little client interaction is encouraged as all eyes are focused on the Superman who monopolizes the conversation. Clients often present themselves as "helpless" or highly dependent and come to each session with a different set of questions or problems.

The Impasse: In the presence of the Superman clients do not learn how to make decisions or resolve problems. Interactions among and between clients are not encouraged so their communication patterns do not change. Clients' self-esteem levels typically fall as they are encouraged and regularly defer to the superior intelligence of the Superman. These clients never make progress because they are not provided with opportunities to grow or learn ways to resolve their own issues. Consequently, they become even more dependent on the Superman. Although everybody seems to be very happy with the therapeutic session, especially the Superman, client change will not occur. Clients and the Superman become stuck because the root of the problem is never addressed seriously, which contributes to the impasse. Typically, clients will remain in therapy for extended periods because of the dependency factors that develop with the Superman.

The Case Scenario: Bridget and Jason are newlyweds and seem to have difficulty with differences in gender roles and their expectations of each other. Bridget's father left when she was nine years of age and she has not had a positive male role model in her life. Jason had trouble learning in school and barely graduated from high school. Each week the Superman answers their questions and lectures them on how they should conduct their marriage. Bridget is enthralled by the strength of the male therapist and Jason is intimidated by the Superman's intelligence. Being young and not wanting to displease the Superman, they do exactly what the Superman says. Gender role differences and expectations continue to be an issue for the couple and are at the base of their arguments. Yet, each time clients attempt to discuss these differences the Superman redirects attention to himself and explains how he, as a male, knows what is best for each client. This response further magnifies the seriousness of the couple's presenting problems. Even though Bridget and Jason do not progress in therapy, they are intimidated and afraid to disagree or question the Superman at any level. Even though change has not occurred and Jason and Bridget continue to experience severe problems related to gender role issues after many sessions, the couple continues in therapy as they believe they cannot function on their own without the Superman's guidance.

The Risk: In order to move out of the role of the Superman, the therapist must practice being psychologically present during the session as a caring human being and demonstrate abilities to focus on the presenting concern. Furthermore, the Superman must develop an understanding that by working together with the clients, meaningful interventions for resolution and positive change can be developed. This is extremely risky for the Superman, who is used to remaining aloof from the clients and relying on his expertise to impart solutions based on his extraordinary intellect.

The Superman must learn how to move away from this "safe" position to one that is more accommodating and collaborative in nature. The Superman must learn to carefully listen to clients, be willing to examine the presenting concerns, actively collect enough information to accurately conceptualize the clients concerns, observe the clients' tensions and comprehend how these tensions influence the presenting problem. The Superman must practice being less active in a session and working hard to create an atmosphere that will allow clients to take risks, grow, and be able to openly express themselves. In this manner, the interactions and tensions around symptoms can surface and be amenable to the therapeutic process.

The Alternative Intervention Style: Impasse Busting: There is a number of professional therapeutic roles that the Superman can utilize to deconstruct a face-to-face impasse with clients. The roles of the Journalist and the Detective provide opportunities to focus more on the clients than oneself. Presenting questions and being curious about those in the therapeutic session will convey a sense of importance to those present, which may enhance clients' self-esteem. The role of the Archaeologist, which promotes an exploration of clients' history, could serve to enhance self-worth and promote a focus on presenting symptoms. The role of the Clown creates opportunities to interject humor into the therapy session, reduce the extreme seriousness that is often present in the Superman's session and help clients to see different views. However, the Clown is a risky role for the Superman because adopting it would create needs to joke, play and be able to laugh at not knowing the answers to all questions asked. The Superman must be open to making mistakes, asking stupid questions, and be willing to obtain information when he does not have answers to client questions. The Bird Watcher would allow the therapist to sit back and allow the clients to have a presence in the session. The roles of the Angel and the Savior may allow the clients to feel safe and provide opportunities for the therapist to communicate that the clients best interests are paramount. However to move to the Angel or the Savior role may be very difficult for the Superman as these roles are diametrically opposed to the preferred role. Although the Superman wants to "save" his clients, he is typically more involved in his own professional therapeutic role as the Superman than in the problematic situation of the clients. The difference between the professional therapeutic roles of the Savior and the Superman is that the Savior risks being overly empathetic with clients while the Superman does not know how to demonstrate empathy.

The Techniques: The Superman could employ a variety of therapeutic techniques or tasks within a session or as homework assignments to deconstruct an impasse. The Superman will need to actively focus on tracking and accommodating client

conversations without interrupting. Rather than simply speaking, the Superman must employ a variety of structural tasks that could involve countersystemic, contextual, displacing, system-restructuring, and reinforcing tasks. All of these tasks would allow the therapist to focus on the clients rather than himself. In addition, the Superman might try to add or subtract systems, focus on the symptom itself or modify the organization of the clients. However, because the Superman often prescribes the rules under which clients respond, these techniques may prove to be less effective.

The Shake-UP of the Case Scenario: Because the Superman is not interested in changing his professional therapeutic role, he is not open to feedback or learning about other professional therapeutic approaches. However, in order to create change in the case scenario above, the Superman could have shifted into the professional therapeutic role of Negotiator. In this role, he could have invited discussions of differences in clients' gender roles from their unique perspectives and explored what they expect from each other in these roles. As homework, the therapist could have asked clients to write down their gender differences with the goals of exploring them and learning how to negotiate new gender roles in future sessions. In the professional therapeutic role of the Archaeologist, the therapist may have elected to collaboratively construct a genogram with the goal of identifying cultural differences in the gender roles in both families of origin. These differences could then be discussed from those perspectives. As the Teacher, the therapist could educate both clients about their own "living culture" and how their "living culture" is creating differences stemming from their family of origin, friends, education and social contexts. When employed by the Superman, these professional therapeutic roles create opportunities for him to connect with clients at a humanistic level and abandon the "all knowing" Superman role.

A primary goal of this chapter has been to highlight the limitations of practicing in the Superman role. However, if after critical self-examination, the reader determines that a place exists for this role in your clinical practice, you may wish to consider case consultation on a regular basis to avoid the pitfalls identified above. Taking such action would present a significant challenge for the Superman.

In retrospect, Bridget and Jason seemed more interested in pleasing the Superman then changing themselves. The Superman appeared to have become a pseudo parent to them and they feared that they would displease the Superman, keeping them stuck in an impasse that led to little change and increased dependence.

The Reflection: In order to determine if the Superman is your preferred professional therapeutic role in a therapeutic environment, it would be helpful to critically examine:

Family Genogram: Were you the person in the family who would attempt to garner attention via your intelligence and accomplishments?

Social Circles: When friends talked about themselves, did you refocus the conversation back to yourself and how good you are in so many things? If you were actively engaged in social clubs, were you the person who needed to be the leader because you knew so much more than others?

School Experience: As a student were you the one in the classroom who strived to be the best of the best? If other students appeared more knowledgeable, did you "talk yourself up" in front of them?

Therapeutic Style: Do you dominate the session by talking about yourself and how you know more about an issue than the clients? Do you often find yourself saying, "Due to my knowledge and experience, I know…..? "

The Teacher

"Children who often interrupt their parents often need attention. I think that we need to look at your parenting style and see how you respond to your child. You know parenting styles can dramatically influence your effectiveness as a parent. For example…" Therapists who adopt the professional therapeutic role of the Teacher are primarily interested in educating clients; thus, every presenting issue is reduced to a lesson, and knowledge is the panacea.

The Teacher provides an educational session atmosphere in which clients learn to fulfill their potentials for intellectual, emotional, physical, spiritual and psychological growth. He structures the session/learning environment by engaging clients in meaningful learning experiences. The Teacher will present instructional resources designed to meet the needs of the clients with varying backgrounds, learning styles (auditory, visual, tactile, perceptual), and special needs. During therapy sessions, the teacher will model values and behaviors consistent with professional and ethical standards and which clients may adapt to address presenting problems.

The Teacher possesses strong oral and written communication skills and is effective at multi-tasking. Although he demonstrates interest in client concerns, the Teacher rarely displays emotional responses. Client interaction is neither encouraged nor explored. One of the Teacher's primary clinical tools is the blackboard, which he uses provide information and explain techniques. He often uses bibliotherapy to promote clients' acquisition of knowledge and to reinforce information provided during therapy sessions. The primary unconscious message to the clients is, "You need to be educated about how to be a better parent, spouse, child, etc."

The Positive Use of the Role: The professional therapeutic role of the Teacher is positively enacted with clients who have limited life experience or exposure to the complex concerns in which they are entrenched. For example, a family faced with a member's new somatic diagnosis such as Tourette's Disorder, Attention Deficit Hyperactivity Disorder (ADHD), Posttraumatic Stress Disorder (PSTD), Bipolar disorders, psychotic experiences etc. may need to be educated about the disorder before the therapist develops interventions for changing the client's rigid and habitual structure or roles around the symptom. Additionally, the role of the Teacher may be useful with clients who have been diagnosed with borderline personality disorders or borderline structure problems by helping them to cope with emotional reactivity. Dialectical behavior therapy is, in part, based on this principle.

The Seduction-Impasse Contributing: The Teacher is seduced into action by clients who present themselves as learners. As clients pose questions about a family member's recent psychiatric diagnosis, the Teacher is often seduced into teaching them about the etiology of the disorder and best treatment options. In this teaching/learning environment it is not uncommon for clients to ask the Teacher to identify an appropriate book or video for their review or, after having conducted their own research, to bring such materials to the session. The Teacher may respond to such requests for information by referring clients to informational websites or by providing a reading list designed to enhance client knowledge.

The therapist may also assume the Teacher role when uncertain of appropriate responses to client expressions of emotion or to obvious tensions among family members. In order to avert client discussions of serious concerns or expressions of strong emotions, the Teacher may use sessions to present information, thereby "protecting" himself from uncomfortable feelings and precluding resolutions to presenting problems. In the learning environment created by the Teacher, clients are disposed to remaining in therapy for a long time. Although clients may perceive a positive clinical experience, both dysfunctional interactions among family members and presenting problems remain unchanged, which contributes to an impasse.

Furthermore, therapists who operate in the Teacher role often have difficulty adjusting to clients who have different opinions about how to integrate special events and/or facts into their lives. Even though these differences presents the Teacher with several solutions from which to choose, the Teacher's unwillingness to act by selecting one of the solutions and desire to only "educate" the members of a therapeutic system can ultimately lead to an impasse.

The Impasse: With an eagerness to help clients understand the IP's symptoms, The Teacher rushes to educate while failing to obtain sufficient information about the presenting concern or its impact on family members. Although clients may communicate satisfaction with the therapeutic process and the Teacher may feel comfortable in his preferred role, clients do not make progress. Systemic change cannot occur because the Teacher has not created opportunities for clients to examine family dynamics that maintain symptoms. In such circumstances, clients may sporadically remain in counseling, but only schedule sessions when they perceive needs for additional information.

The Case Scenario: Andrew entered the session without making eye contact with the Teacher. He appeared be exhausted and anxious as he sat in a slumped position with his eyes cast at the floor. Andrew reported that he was 28 years of age and that he had just been promoted to a managerial position at the store where he was employed. He

said that he was responsible for managing five subordinates and for insuring that each met daily sales quotas specified by the store owner. Andrew stated that he was initially excited about his promotion, but that he had lately been "having problems" with daily functioning. He reported that, after leaving work, he began to sweat, had difficulty breathing, and felt dizzy, which raised fears that he may be seriously ill.

As the Teacher listened to Andrew's concerns, she pulled a book on anxiety and phobias from her book shelf. She shared her belief that Andrew was experiencing panic attacks and that the problem could be "fixed" if he understood how panic attacks develop. The Teacher then spent the next 30 minutes reviewing the book with Andrew and strongly encouraged him to purchase it. The Teacher asked Andrew to read the first two chapters during the next week and to return in one week for another session, during which they would discuss what Andrew had learned and how the information could be used to help him. The Teacher also explained that the book included a number of exercises that they would practice together in following sessions. After five weeks, Andrew's panic attacks had ceased and he terminated therapy.

Six weeks later, Andrew returned to therapy and said that his anxiety attacks had returned. The Teacher and Andrew revisited the bibliotherapy assignments and, once more, Andrew's anxiety attacks ceased. In response, Andrew again terminated therapy. Three months later Andrew phoned the Teacher to report that his panic attacks were occurring on a daily basis, but that they had become so intense he "felt certain that he was going to die." Andrew said that he did not want to return to therapy because he had his "book" to review. However, Andrew stated his intention to seek a prescription for "anxiety pills" from his family physician.

The Risk: In order to move out of the professional role of the Teacher, the therapist must be willing to create appropriate levels of client discomfort and also be comfortable with the discomfort created. This is extremely risky behavior for the Teacher, who is most comfortable in an instructional position. If clients are kept too comfortable in a session, they will not be motivated to change. Consequently, system homeostasis will be maintained and presenting problems cannot be resolved. Simply put, if the Teacher wants to create client change, he must motivate him to engage in behavior that is somewhat risky and uncomfortable. The Teacher must create conditions in the therapy session that will permit family tensions to rise so that behavior patterns around the presenting concern can be identified in both verbal and nonverbal interactions. The creation of tension is especially discomforting for the Teacher, who desires to educate clients in order to establish and maintain family harmony. Adding to his discomfort is the Teacher's awareness that he may freeze and not know how to respond to clients who present strong emotions such as anger, deep sadness,

grief, or depression. To help the Teacher adopt and practice techniques associated with creating and maintaining client discomfort, he may secure the services of a seasoned supervisor or consultant. This professional approach may provide specific training in dealing with the present moment, staying with the presented affect, and engaging in new intervention and therapeutic approaches.

The Alternative Intervention Style-Impasse Busting: There is a number of professional therapeutic roles that Teachers may utilize to deconstruct a face-to-face impasses with clients. Assuming the professional therapeutic role of the Journalist permits the therapist to gather relevant information about the presenting problem and how the clients have organized themselves around it so that appropriate interventions can be developed. Shifting into the role of the Archaeologist creates opportunities for the therapist to investigate family histories and how family members may be contributing to the identified patient's current medical condition or presenting behaviors. Adopting the role of the Clown allows the therapist to present as more personable, more approachable, and more fully human to the family. Shifting into the roles of the Savior or the Angel enables the therapist to intervene, connect, and demonstrate commitments to working with the family on both personal and professional levels. Embracing the role of the Bird Watcher allows the therapist to maintain appropriate emotional distance from clients, create clear professional boundaries, and reduce personal reactivity, all while remaining attuned to client emotional responses. Adopting the professional therapeutic role of the Doctor enables the therapist to garner deeper understandings of clients' somatic presentations and how they may limit the therapist's choice of clinical interventions. Assuming the roles of the Mediator and the Referee may be effective when family tensions rise and feedback from an impartial third party may prove useful in facilitating discussions of contentious family issues. Through the skillful adoption of these alternative roles, the therapist may instill hope into family systems characterized by chaos, sadness, anger, and hopeless.

The Techniques: The Teacher may employ a variety of techniques or tasks within a session or as homework assignments to deconstruct an impasse. He may use countersystemic tasks to expose homeostatic family dynamics or system-restructuring tasks to promote more effective interactions among family members. The Teacher may choose to exaggerate the symptom, deemphasize the symptom, focus on another symptom, re-label the symptom, reinforce the symptom, or alter the affect around the symptom. In using such techniques, the therapist must create an emotionally safe therapeutic environment that affords opportunities for habitual transactional and relational patterns to emerge and be observed. In order to enhance technique

efficacy, the Teacher may need to reorganize, construct, reinforce and prescribe rules on how to respond to the presenting concerns or somatic situations.

It is worth noting that use of these more sophisticated techniques assumes therapist competence in a host of more fundamental skills and techniques that include: tracking; accommodating; helping family members become cognizant of their nonverbal communications; allowing tension to build in sessions; developing implicit conflict; disassembling clients' organizational structure by highlighting individual differences; and, instilling hope.

The Shake-UP of the Case Scenario: In the case scenario above, Andrew saw his general practitioner who referred him to another therapist. Operating in the professional therapeutic role of the Detective, the new therapist initiated therapy by creating a session environment characterized by psychological safety. He then explored the circumstances (i.e., antecedents, immediate conditions) in which Andrew's anxiety attacks occurred. In particular, the Detective investigated stressors Andrew experienced just prior to these attacks. At the end of the session, The Detective assigned a homework task by asking Andrew to write down the primary stressors he experienced each day and to document his responses to them. The therapist asked Andrew to carry a small notepad, to record this information as soon as possible after he experienced an anxiety attack, and to report this information during their next therapy session.

In the next session, Andrew reported that he became most anxious when his supervisor questioned him about the productivity of his "five" employees. Andrew then said that the supervisor reminded him a lot of his father, who was very religious, rigid, and who had very high expectations of him. In a trailing voice, Andrew said that he could never please his father. At this point, the therapist shifted in to the role of the Archaeologist and asked Andrew to bring his father into a session. While initially hesitant to comply with this request, both Andrew and his father eventually agreed. During a joint session, Andrew learned that his father was very proud of him and that he had voiced such high expectations (i.e., "be responsible," "be a man") for one overriding reason. The father said that because of his debilitating medical condition, he knew that if he should become disabled or die, Andrew would have to assume financial and familial responsibilities for his mother and three siblings. Andrew responded to this revelation by telling his father that he thought he was simply being overly critical and that he thought that his father had no faith in him. He told his father that he never realized that his injunctions to be the "man" of the family were motivated by concern for the welfare of his mother and siblings. During the course of therapy over the next three months, Andrew's anxiety attacks waned

and then ceased. Andrew became more self-assured and developed effective coping strategies for responding to work-related stressors, especially those associated with his supervisor's vigilance and high expectations.

In retrospect, the Teacher utilized a "cookbook" approach, which had limited success. Andrew gained insights into the causes of anxiety attacks and "learned" strategies to cope with them. However, the underlying dynamics that supported Andrew's symptoms (i.e., anxiety attacks) were not revealed until the Archaeologist explored Andrew's past, which helped him to reconcile his father's vision of his son with Andrew's vision of himself. With this understanding, Andrew became more self-confident, his anxiety attacks resolved, and he developed effective skills for managing daily stress.

The Reflection: In order to determine if the Teacher is your preferred professional therapeutic role in a therapeutic environment, it may be useful to explore:

Family Genogram: Did you "educate" family members about appropriate behaviors in novel circumstances? Did some family members refer to you as "Miss/Mr. Manners?"

Social Circles: When friends were hesitant to complete a task, did you teach them the best way to approach it? If you were actively engaged in social clubs, did you assume responsibility for teaching others about the best options for completing an activity?

School Experience: Did you reinforce information provided by the teacher and regularly serve as a tutor to classmates? If other students complained about completing an assigned task, did you attempt to "educate" them about the value of the assignment?

Therapeutic Style: Is your gut reaction to educate your clients? Do you often use bibliotherapy in working with clients? Do you frequently use a whiteboard or written materials to educate your clients? Do you often find yourself saying, "I need to teach them about…"

Part 3

The Shake-UP in Action

Chapter 23

The Shake-UP

The Impasse

Have you ever experienced saying one the following phrases or similar phrases to yourself during a session?

I am overwhelmed…
I have to do something…
I am stuck…
I am drowning and have no place to go for help…
Slow down…
Gosh, I am so intelligent I know…
NO, NO, NO! We do not need that information. STOP!
I need more clues… they are hiding something!
"I need to break the tension with some humor, now!"
"Wait, they can do this, then do this…"

If so, you may have been experiencing an impasse with your clients. When you find yourself feeling uncomfortable, stuck, and not knowing where to go next, pay attention! These responses signal a need to draw upon aspects of your "living culture" that may be temporarily dormant, but for which access is needed to determine transference dynamics and your preferred professional therapeutic role in the session. In order to de-construct the impasse, it may be necessary to shift into a different professional therapeutic role to "shake-UP" session dynamics and apply alternative therapeutic techniques or tasks.

De-Constructing the Impasse: Shake-UP

As previously noted, nearly all therapists experience impasses with clients and such experiences do not indicate therapeutic incompetence or failure. Although most therapists are successful most of the time in using preferred professional therapeutic roles, the development of an impasse suggests a need for change. In such cases, it is common that a preferred professional therapeutic role, techniques and/or tasks have become rigidified and are no longer effective in promoting client change. The impasse is a significant therapeutic event. The therapist's response to it can make or break the clinical relationship and the willingness of clients to remain invested in the therapeutic process.

When seduced by a particular client's typology and an impasse develops, you may come to believe that you are unproductive and unable to help clients. You may become confused, overwhelmed, and uncertain as to how to move past the impasse. In such circumstances and with information gleaned from this book, you may also find yourself better positioned to consider your presenting "living culture" and to identify your preferred professional role(s), techniques and tasks. You may also practice the use of alternative professional therapeutic roles and techniques with the goal of "shaking-UP" the therapeutic process in order to de-construct impasses. Before terminating therapy due to an impasse, it is incumbent on the therapist to take stock of the clinical situation by calmly engaging in a process of self reflection that includes the following elements:

(a) step back;
(b) reflect upon the professional therapeutic role that you are utilizing;
(c) think about how clients are seducing you into this role;
(d) identify clients' presenting typology; and,
(e) re-position yourself within the therapeutic alliance by selecting a more productive professional therapeutic role(s) (chapters 5-22) or therapeutic technique(s) and tasks overviewed in chapters 3 and specified in chapters 5-22.

Re-positioning your professional therapeutic role creates opportunities to re-establish trust, regain control of the session, and provide more effective services. Further adopting a new interactional style as described in chapter 4, the therapist is better positioned to promote systemic change in a manner consistent with client goals.

Selecting a Professional Therapeutic Role

Client typology will typically determine the professional therapeutic role activated during initial sessions. The selected professional therapeutic role should be based on presenting issues, client affect, level of engagement between clients and the seriousness of presenting concerns. Clients present with an array of concerns that may suggest, and sometimes seduce, the use of a particular professional therapeutic role. For example, when clients present with strong needs for hope and guidance, the professional therapeutic roles of the Angel or the Savior may be appropriate and beneficial. Family members who say little but portray communication through nonverbal interactions may benefit from the Bird Watcher approach. Families who present with rigid rules and weighty concerns may benefit from a therapist who adopts the professional therapeutic role of the Clown. The Construction Worker

professional therapeutic role may be best suited for families who convey vast amounts of erroneous information.

When clients present with highly complex issues and many different viewpoints, the professional therapeutic roles of the Archaeologist, the Detective, and the Journalist may be useful. For clients presenting with clear physical and neurological concerns, the professional therapeutic roles of the Doctor or the Teacher may be use suitable choices. Clients in crisis may benefit from the assistance of the Firefighter. Clients who present opposing sides of critical family matters may best be served by the professional therapeutic roles of the Judge or the Mediator. The Preacher may best serve clients who present with very strong ethical beliefs or values.

Enmeshed clients may benefit from a therapist who operates in the role of the Referee while disengaged clients may respond best to a therapist in the Secretary role, who adeptly records both verbal and nonverbal communications. Adoption of the Sailor role may be appropriate for clients who need little direction and who are self-motivated. The professional therapeutic role of the Teacher may be beneficial for clients who are insecure, have low self-esteem and/or present as learners.

As noted above, client typology typically induces a particular professional therapeutic role during initial sessions. However, it is critical to note that typology serves as both a basis for appropriate initial role selection and as a potential "trap" for therapists whose preferred professional therapeutic role is activated and maintained by such typology. Consequently, as you come to understand clients' concerns and your preferred professional therapeutic role, it will be critical periodically to assess the effectiveness of your chosen role and to shift in and out of various professional therapeutic roles as determined by client needs.

Information Gathering

Information gathering is the primary therapeutic technique used to identify a fruitful approach for working with family members and to promote change in the clients' contextual system. All of the professional therapeutic roles examined in this book, except the Superman, support the critical task of gathering information. Each professional therapeutic role can be positively enacted to move out of an impasse when engaged with various client typologies. To do so, when working with clients, the therapist must be able to explore and extract meaning for both clients' and his own "living cultures" in order to respond effectively to clients' presenting typology. When an impasse develops, the therapist must re-position himself in the system by adopting an alternative professional therapeutic role that reduces or eliminates the impact of the clients' seductive typology. Although moving out of a preferred professional therapeutic role may feel awkward or uncomfortable, the therapist is obligated

to take this risk. He must develop facility in using a number of alternative professional therapeutic roles and expand his repertoire of therapeutic techniques and tasks in order to acquire information required to re-shape the "presenting" culture.

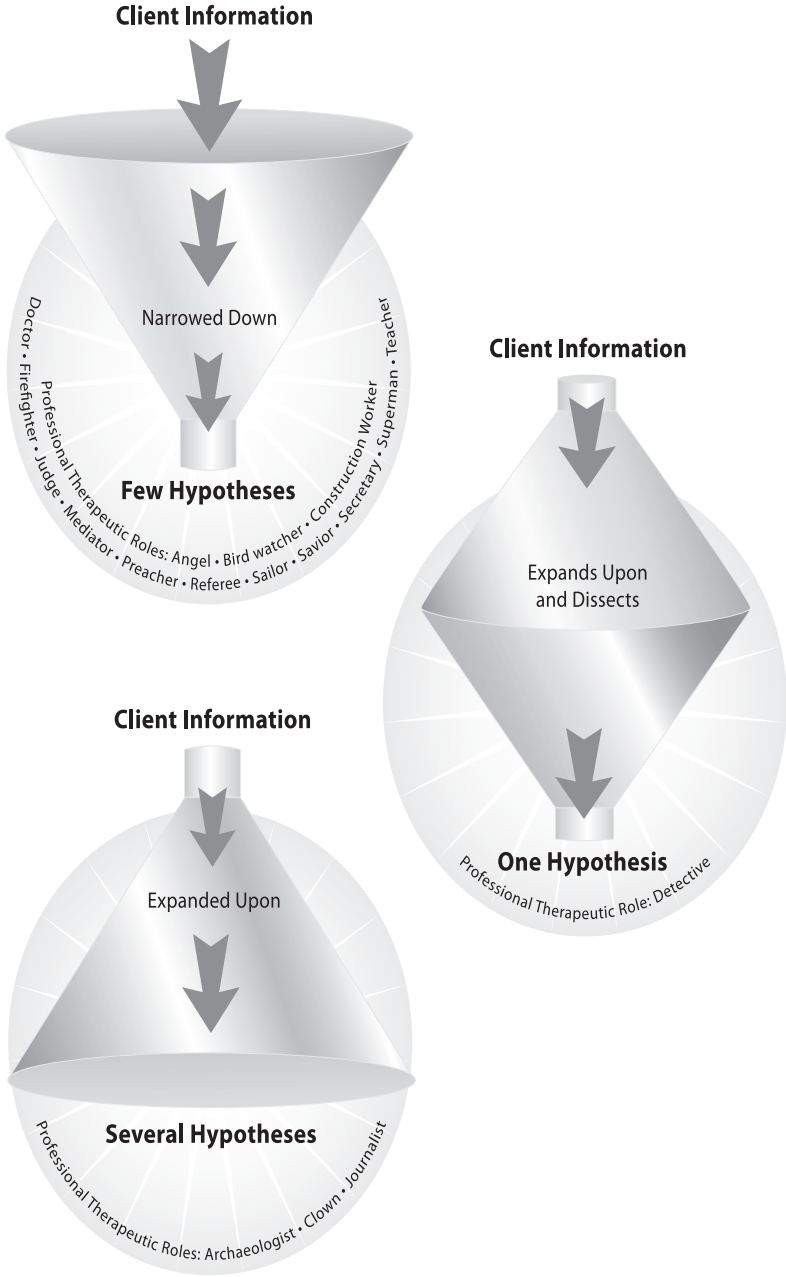
The therapist needs to remain cognizant of the centrality of the information-gathering task throughout the therapeutic process. In order to be successful, he must enact those professional therapeutic roles and therapeutic techniques that will bring the most flexibility, curiosity, and playfulness into the session. Doing so will allow him to gather more comprehensive information that will be used to understand system dynamics, identify hypotheses regarding the maintenance of clients' problems, and create effective treatments.

The Funnel Approach

During practica in Rome, Italy Maurizio Andolfi often made reference to the inverse funnel theory (see Figure five, The Funnel Concept).

Figure Five

The Funnel Concept



The inverse funnel approach suggests that when a therapist first meets clients, he is presented with only a minimal amount of information (top opening of the funnel) in regard to the presenting concern. The therapist is responsible for gathering (the tube of the funnel) and expanding upon the information (base of the funnel) by employing a variety of therapeutic techniques, tasks, and professional therapeutic roles in order to move clients out of their areas of "interactional stuckness." Maurizio Andolfi suggested that when a therapist feels stuck with those present in the session, he needs to expand upon information by inviting clients to bring extended family members, friends, and other key people capable of providing more detailed information regarding clients' issues and dynamics to future sessions. He further suggested that if key informants could not attend sessions due to distance or other limitations, a telephone conference could be conducted. According to Maurizio Andolfi, more people produce more information and more information typically leads to more effective interventions and solutions that, in turn, lead to permanent change within the client system.

In analyzing figure five, the reader will observe that therapists operating in the professional therapeutic roles of the Angel, the Bird Watcher, the Construction Worker, the Doctor, the Firefighter, the Judge, the Mediator, the Preacher, the Referee, the Sailor, the Savior, the Secretary, the Superman, and the Teacher have a tendency to deduce information to a limited number of hypotheses when in an impasse, which restricts abilities to create effective and lasting interventions for clients. Similarly, the Detective when in an impasse expends a great deal of energy exploring each and every clue presented, develops a number of "guesses" and then deduces to a single hypothesis that severely restricts opportunities for clinical progress. These approaches may result in creating further disorganization and problem maintainance.

On the other hand, therapists, when faced with an impasse, who adopt the therapeutic roles of the Archaeologist, the Clown and the Journalist, apply the "reverse funnel approach" endorsed by Maurizo Andolfi. These therapists collect client information, expand upon it by implementing a host of therapeutic tasks or techniques such as humor, and then develop multiple hypotheses. Through the process of hypothesis testing, therapist and clients identify system dynamics and develop treatments designed to achieve effective and permanent structural and contextual change, thereby eliminating the need for an IP. By implementing the reverse funnel approach in the therapeutic session, the therapist re-positions himself into a new professional therapeutic role that creates opportunities to expand upon information and de-construct the impasse.

As a reader, you may use the funnel concept to help select which approach would be most useful with the type of information that is being presented by the clients. For example, if too much information is being presented and an impasse is developing then the professional therapeutic roles of the Archaeologist, the Clown or the Journalist may not be useful. The therapist may want to employ one of the professional therapeutic roles in the "funnel". On the other hand, if not enough information is being gathered and there is much tension within the session, then selecting one of the professional therapeutic roles in the "reverse funnel" may be a better approach for information management and imploding of an impasse. When the clients present highly complex situations and the therapist needs to expand and dissect the presented information the "Broader" funnel (the Detective) approach will help narrow highly complex information which will create options especially when opposing viewpoints are provided simultaneously.

The Unique Roles of the Archaeologist, the Clown and the Journalist

In order for therapy to be effective clients must understand how past experiences, particularly those within their family of origin, influence current interactional behaviors and communications within their contextual system. Perhaps the three most salient professional therapeutic roles in promoting such understanding are those of the Archaeologist, the Clown, and the Journalist. These roles are perhaps also the most effective in creating permanent structural, interactional and communication changes in clients' systems. By activating these roles, the therapist may also be better positioned to move beyond therapeutic impasses. Despite their efficacy, caution is indicated in adopting these roles that can lead to an impasse if played out in a rigid and prolonged manner (see chapters 6, 8, and 13).

The roles of the Archaeologist, the Clown, and the Journalist can be applied to any client typology. When an impasse develops, adoption of these roles may assist the therapist in moving past the current therapeutic impasse by expanding on available information and collecting additional critical information (inverse funnel approach). The Clown is a very unique professional therapeutic role and best to use when tensions are very high within the therapeutic session. As information is gathered, the Clown, in order to keep an impasse from developing can interject humor, laughter, creativity, or playfulness into the session. This will create levity when a negative atmosphere is sustained by information which is creating conflict or escalating tensions between clients.

As information is gathered and integrated into a comprehensive family history, the Archaeologist, the Clown, and the Journalist share it with family members in order to promote awareness of how current and generational family interactions

serve to maintain symptoms. In collaboration with the Archaeologist, the Clown, and the Journalist, clients work to modify and improve each other's functioning with the goal of producing lasting changes in the clients system.

Cross Mapping of the Professional Therapeutic Roles

The professional therapeutic role adopted by the therapist is not necessarily a dynamic one. However, as previously noted, most therapists adopt and utilize a preferred professional therapeutic style. Each professional therapeutic role is associated with a unique constellation of therapist characteristics, attributes and behaviors. Perhaps of greatest importance to clients are the therapist's level of control as demonstrated by authoritarian attitudes and behaviors and level of involvement with clients' presenting issues. Figures six, Level of Client Involvement for Professional Therapeutic Roles, depicts how each professional therapeutic role falls upon a continuum related to level of involvement with clients from being overly involved to very disengaged. Figure seven, Level of Therapist Control for Professional Therapeutic Roles, illustrates how each professional therapeutic role falls upon a continuum related to level of control with clients from being very authoritarian to very passive.

Figure Six

Level of Client Involvement for Professional Therapeutic Roles

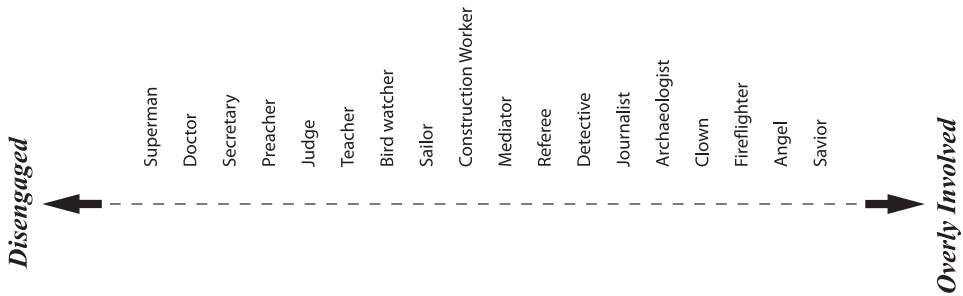


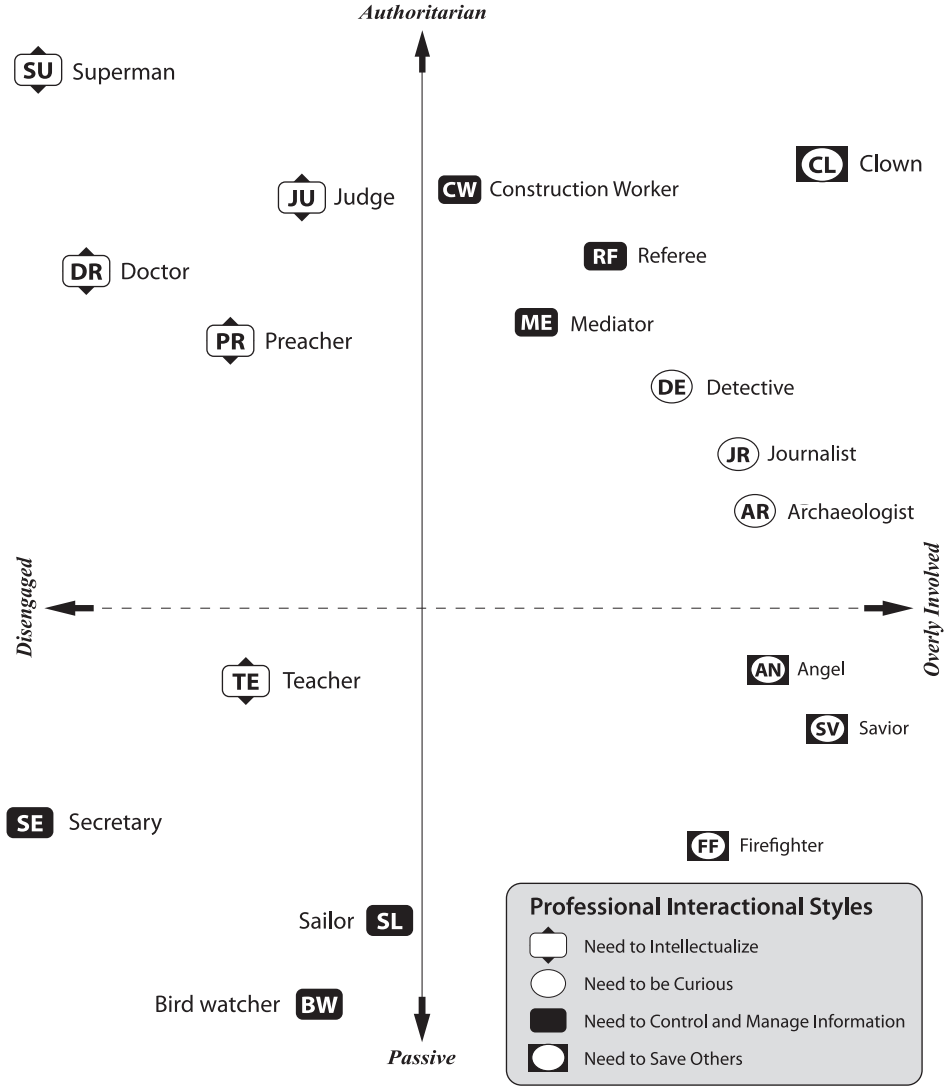
Figure Seven
Level of Client Control for Professional Therapeutic Roles

Each professional therapeutic role can be placed on a continuum or a cross map (see figure eight, Cross Mapping of Professional Therapeutic Roles and Interactional Styles), which provides an index of a therapist's level of control with clients (e.g.,

authoritarianism) and level of client involvement (e.g., overly involved). The following cross map demonstrates the potting of each professional therapeutic role in relation to degree of authority displayed and level of client involvement.

Figure Eight

Cross Mapping of Professional Therapeutic Roles and Interactional Styles



In figure eight, the dotted line (--) indicates a continuum of professional therapeutic roles that range from over-involvement to disengagement with clients. The heavy line (-) represents the level of control associated with each professional therapeutic role

and which ranges from a very authoritarian approach to a very passive approach. Each role is also depicted in relation to the key interactional style that is portrayed to clients within a session (Need to Intellectualize, Need to be Curious, Need to Control and Manage Information, and Need to Save others).

This cross map can be used to help the therapist determine his personal dynamics related to these two variables and also reveal alternative professional therapeutic roles that may be more productive should an impasse develop. For example, let's imagine that a therapist is using the professional therapeutic role of the Angel and an impasse has developed with the clients. The therapist is cognizant that clients have become disillusioned and are thinking of terminating therapy. In order to redress this situation, the therapist considers an alternative professional therapeutic role. By reviewing the cross map, he is not only able to identify how his current professional therapeutic role is related to the dimensions of client control and client involvement, but also is able to examine alternative roles that offer opportunities to function on these dimensions in ways more consistent with client needs. In addition, the cross maps helps the therapist identify which preferred interactional style may be needed with certain clients.

The Angel determines that he should be less involved and more authoritarian. After reviewing the cross map to determine the placement of each therapeutic professional role on the continuum, the Angel adopts the role of Preacher because it provides greater opportunities to meet client needs from a control and involvement level and allows the Angel to be more intellectualized.

The cross map serves as a quick reference guide for analyzing each therapeutic role, level of client involvement, level of therapist control and professional interactional style connected to each role.

Chapter 24

The Process of Self Reflection

Now that you have read chapters 5-22 and have a clearer understanding of the professional therapeutic roles described in this book, you may find it useful to reflect upon the interactional styles and roles that you have unconsciously adopted in various familial, social, and therapeutic settings. During your reflection, pay particular attention to the behaviors that you adopted when family or friends were in a conflicted state. How did you respond in these conflicts? Did you give advice? If so, what type of advice? Did you attempt to resolve the conflict? If so, what strategies, techniques, or roles did you adopt? As you read this chapter, take time to speak to your family of origin members as well as high school and college friends in order to identify the behaviors that you unconsciously demonstrated during interactions with them. It is imperative that you identify the interactional behaviors that you employed during developmental experiences (i.e., family, school, social clubs) because these behaviors will be unconsciously reflected in the way you shape your professional therapeutic sessions. Knowing your behaviors in these contexts will assist you in identifying your preferred professional therapeutic role(s) as well as the "living culture" that you bring to every therapeutic setting.

Family, School, Friends and Learned Societies

As a child, adolescent, and young adult you adopted certain interactional behaviors that allowed you to cope with the demands of different social settings and relationships. Over time, you unconsciously adopted certain behaviors, which served as the foundation for your preferred interactional role. Functioning in your preferred role enabled you to manage the vagaries and challenges of social interactions, especially when tension or conflicts arose.

As you identify your preferred interactional behaviors and roles, you may recognize that you continue to display these behaviors not only in your family of origin but also with your current partner, spouse, and/or children. With a bit of additional exploration, you may discover the roles that members of your family of origin assumed during your childhood and learn how these roles (behaviors) helped reinforce the behaviors that you automatically employ with people in general.

In order to begin the process of identifying your personal and professional therapeutic roles, we offer the following suggestions, tasks, and questions. They are designed to promote a deeper understanding of your "living culture" and personal

interactional style when working with clients. More specifically, this process is designed to help you:

(1) Identify the particular therapeutic role that you unconsciously adopt in responding to a client's seduction (impasse contributing behaviors); and,
(2) Adjust your behavior or shift into another therapeutic role to de-construct the impasse.

Development of a Therapeutic Professional Role

Investigating My Preferred Role in Life

The following activities have been designed to promote reflection on your continuum of life, which includes relationship dynamics in your family of origin, with peers, and in various social and school settings. The process will aide you in identifying unconscious roles or behaviors that you may have assumed when engaged in such interactions, particularly when interpersonal conflicts arose.

Your "Living Culture"

Before engaging in the activities identified below, it will be important for you to thoroughly examine your "living culture". Refer to Figure Two, *Living Culture,* to assist you. Based on information presented in this figure, *draw your own "living culture"* and think about how significant others throughout your life (alive and deceased) have positively or negatively shaped your interactional style with family members, friends, professional colleagues and clients. As you reflect upon your drawing and the persons you included in your "living culture", determine those who may be of greatest assistance in completing the following tasks:

1. Contact members in your family of origin and check the accuracy of your recollections of both your own and their interactional styles during your childhood.
2. Ask your family members how they perceived your behaviors as a child... during adolescence...and now?
3. Contact friends from high school and college and discuss with them how they perceived your behaviors and roles in various interactions, especially when tensions or conflicts emerged.
4. Create your own family of origin genogram. Focus on the conflicts within your family of origin and reflect upon how you typically responded to tensions between and among family members.

My Role as a Therapist

After obtaining answers to the above questions, think about your preferred ways of interacting with clients, your preferred professional therapeutic role, and how you typically respond to clients when tensions or conflicts arise (between/among clients or between clients/you):

1. How much client information do I typically gather in a session before implementing tasks or therapeutic techniques?
2. Am I easily seduced into solving clients' presenting problems, even before gathering critical information such as clients' histories, family dynamics and interactional patterns?
3. Do I encourage clients to examine interactional patterns in their families of origin and help them to understand current problems in light of such patterns?
4. Do I take time to construct a family genogram with clients?
5. Am I judgmental in my work with clients? Do I unintentionally work to impart my beliefs, opinions, and values on clients?
6. How do I respond when tensions or conflicts arise in the session? Am I comfortable with allowing tensions to emerge as a natural consequence of family differences or do I work to eliminate them as quickly as possible?
7. How much do I use humor in a session?
8. How do I know when I am at an impasse? What are my cognitive and emotional responses? Do I freeze, become bored, end the session, make a referral, talk to myself?
9. Do I respond to all clients with the same professional therapeutic role or do I adjust my professional therapeutic role from client to client based on presented typology?
10. Do I rely on the DSM-IV-TR to diagnose clients and quickly refer them to specialists for additional medical/pharmacological treatments?
11. How do I respond to a crisis? Do I act thoughtfully, efficiently, and in the clients' best interests?
12. Do I permit clients to call, text, or email me between therapy sessions?
13. Do I work hard to make everyone in the session happy?
14. Do I try to control the session by controlling who speaks to whom and when?
15. Am I uncomfortable with enmeshed systems?
16. Do I assume responsibilities that rightfully belong to my clients?
17. Am I likely to record notes during sessions rather than at their completion?
18. When in session, do I often find myself lost and wishing the session were over?
19. Do I dominate sessions by talking about myself rather than clients or by presenting myself as an expert who knows more about a situation than the client?

20. Do I interrupt clients or quickly ask a question when they attempt to share feelings of anger, rage, deep sadness, or other powerful emotions?
21. Do I ask question after question without looking at the ecological aspects of presenting concerns?
22. Do your clients get annoyed when you attempt to use humor or joke with them?
23. Are you likely to listen to *each* client's desires or wishes before making a treatment recommendation? Are your treatment recommendations designed to accommodate the needs of all family members or a subset of family members?

Based on your answers to all of these questions, identify your preferred interactional styles and professional therapeutic roles from those presented in this book:

_____

_____

_____

_____

_____

_____

Difficulties in Adopting Alternative Professional Therapeutic Roles

Information gleaned from completing the above activities is designed to create self-awareness of professional functioning and encourage positive changes in therapeutic relationships. As appropriate, we encourage you to practice "role shifting" during therapy sessions in order to address client concerns more effectively and to develop skills in resolving therapeutic impasses. Should you experience difficulties shifting into alternative therapeutic professional roles, we recommend that you seek a professional consultation.

Andolfi and Haber (1994) wrote extensively on the benefits of using consultants in their edited book, *Please help me with this family: Using consultants as resources in family therapy.* Although this book is an excellent resource for professional development, you may also consider arranging a consultation session with a consultant, yourself, and clients. Should this arrangement not be possible, an alternative approach may prove to be equally effective. First, seek the services of a seasoned therapist who is also an experienced consultant. During the consultation session:

(1) Explain your interactional style and preferred therapeutic role(s);
(2) Jointly review a videotape of a recent therapy session in which an impasse developed;
(3) Solicit consultant feedback on the relationship of client dynamics to your preferred interactional style and therapeutic role in the development of the impasse;
(4) Seek feedback on alternative therapeutic roles that may have been effective in "shifting out" of the impasse; (5) comprehensively and honestly explore reasons you did not/could not make such shifts during the therapy session;
(6) Ask the consultant to model role shifts that could have been implemented in the session; and,
(7) Practice "role shifting" opportunities by pausing the recorded session at appropriate points, demonstrate behaviors or techniques consistent with the alternative role, and solicit evaluative feedback from the consultant.

The Shake-UP in Motion

The following case scenarios were designed to illustrate how therapists may resolve therapeutic impasses by consulting with an experienced supervisor. In each case, the therapist had reached an impasse with clients. Through the consultation process, therapists were able to successfully shift from one therapeutic professional role to another, the impasse was "busted" and proper therapeutic interventions were implemented. Each case further demonstrates how individuals with psychosis were able to make productive life changes.

Case 1: "Call the Doctor, Please"

This following case will demonstrate how a therapist can quickly shift from one therapeutic role to the next. In this case the Shake-Up consisted of the professional therapeutic roles of Mediator, Doctor, Journalist, Judge, Teacher, and Archaeologist.

A couple presented at an outpatient clinic of a psychiatric institute and was assigned to a resident therapist. After speaking with the couple for an hour, the therapist met with his supervisor to report that he was "stuck" and did not know how to proceed. He reported to the supervisor that the husband had brought his wife to the clinic in order to "get her diagnosed and fixed." The couple had reportedly worked with many therapists in recent months, but none were able to make an accurate diagnosis. The husband believed his wife was depressed because she no longer spoke to him and avoided him most of the day.

The therapist told the supervisor that, during the session the husband spoke extensively about the struggles that he had with a "group" of people who wanted to "destroy" him. He had presented to the resident therapist a notebook that documented "proof" of his claims. The notebook had many letters written by the husband to various lawyers, politicians, and even the Queen herself. In the letters, the husband wrote that the Queen was in extreme danger by the same "group of people" that wanted to destroy him. The husband reported that, for more than ten years, he had "gone to court to get this group condemned," but that all of the lawyers he had hired were in the same camp as "those criminals." As a result, the husband stated that they refused to represent him.

The resident therapist further shared that, during the interview, the wife remained silent, provided no information, and made no eye contact. The supervisor suggested that the resident therapist meets alone with the wife to determine

if she would respond differently when the husband was not present. The resident therapist shared that he had made this proposal, but that the husband had refused to allow such a meeting.

Upon receiving this report, the supervisor adopted the professional therapeutic role of the Doctor. He and the resident therapist met with the couple, at which time the Doctor told the husband that the therapist needed to meet individually with his wife in order to make an accurate diagnosis. The husband granted permission and then asked the supervisor if he wanted to read his notebook while his wife was in session with the resident. The supervisor agreed.

During the individual session with the resident therapist, the wife began to weep. The therapist shifted into the professional therapeutic role of the Journalist and encouraged a thorough discussion of her husband's psychiatric history. She said that over the previous ten years, her husband had become increasingly convinced that "people" wanted to destroy him. She stated that her husband had reported receiving "threats" shortly after his business failed, approximately 12 years ago. She further reported that her husband had blamed others for the failed business and told her that people had co-plotted against him to destroy his business. Shortly thereafter, he reportedly became hyper-focused on the plot, constantly seeking proof of its existence. He then reportedly began to write and consult with many lawyers. The wife further reported that, for more than ten years, several lawyers had contacted her to report that they believed her husband "was ill and needed medical attention."

The wife said that, on numerous occasions, she had spoken to her husband about the possibility that his perceptions may not have been accurate and that he may benefit from a discussion of his concerns with a doctor. In response, her husband became angry and hostile, accusing her of being part of the "group" that wanted to destroy him. The wife stated that, as her husband's symptoms increased in severity, she stopped speaking to him in order to avoid angry outbursts that included both verbal insults and physical attacks. She said that as she limited communications with her husband, he became convinced she was ill and told her that she needed to consult with a doctor.

The wife said that she had met with her general physician (GP) without her husband and asked for his help. The GP, who operated in the professional role of Mediator, reportedly tried to negotiate a solution with her and her husband, but without success. In the end, he reportedly told the wife that he could not help her because her husband would not pursue therapy. She said that she had to accept the situation because her husband had threatened lawsuits against the professionals if they tried to intervene against his will. The wife said that, despite her husband's threats, she continued to periodically meet with physicians to seek help for her

"illness." She reported that one of the physicians suggested that she consult a psychiatrist to discuss her problem. She reportedly consulted with two psychiatrists, presenting herself as the patient to both. Both psychiatrists, who also operated in the professional therapeutic professional role of the Mediator, reportedly told her they could not help her if the husband did not accept therapy. The wife said that neither psychiatrist spoke to her husband regarding their conclusion that he most likely suffered from a psychotic breakdown.

The wife said that she had stayed with her husband because she hoped that he would change over time. Now, she had realized this was not going to happen but said that she could not leave her husband because she feared that he could not care for himself.

Following their individual sessions with the husband and wife, the resident therapist and supervisor met to share information and discuss the problem. The supervisor indicated that he believed the resident therapist should shift out of the professional therapeutic role of the Mediator and stop avoiding a conflict with the husband. The consultant told the therapist that it would be extremely difficult to discuss the true nature of the couple's presenting problems and keep the husband in therapy; but said that they had to accept the risk. The supervisor then shifted into the professional therapeutic role of the Judge because he felt it necessary to make a determination of which client needed psychiatric treatment. He would announce a "verdict" in order to connect with the interactional style of the husband.

The resident returned to the couple and, in a serious tone of voice, said that the supervisor had important information to share. The husband said that he was pleased to hear that the supervisor had become involved in their case because he thought that the resident therapist was too inexperienced to draw a correct conclusion. The supervisor entered the therapy room and said that he had some very difficult information to share with the husband and wife. He asked them if they were willing to hear his conclusions and to remain silent until he had finished making a complete statement of his findings. Both the husband and wife readily agreed. The supervisor then said," I know this will be a shock for both of you, but I must inform you (looking at the husband), that you are suffering from what we call a severe and prolonged paranoic psychotic breakdown and that you require immediate intensive treatment."

Both the husband and wife were silent for several minutes. Then the husband said, "So you also belong to "the group" that wants to destroy me." The supervisor responded, "Are you certain of this belief? If so, then it proves that my conclusion is correct. Your response reveals an inability to process information rationally." So, I ask you to calm down and to listen to my explanation.

The supervisor then shifted into the professional therapeutic role of the Teacher and explained to the couple the complexities of psychotic thinking. He said that such thinking is not proof of madness but is a special way to experience the world, all of which is motivated by mostly unconscious, intense and complex problems that cannot be easily resolved. The supervisor then explained that it would be necessary to speak with both of them about these intense experiences, which could only be understood by exploring the husband's life and family history. The supervisor said that the husband would also need to take medication designed to reduce his anxiety, help him to think more clearly, and ease his intense distress.

The wife then said, "What do you advise me to do now?" The supervisor said, "I cannot make that decision for you, but I think you should consider leaving your husband if he refuses to enter therapy and take prescribed medications." Upon hearing the Teacher's comments, the husband became very angry and left the room. His wife followed him.

A week later the wife called the clinic and shared that she had decided to leave her husband because he had refused to enter therapy. She said that she was pleased with the supervisor's intervention because it had enabled her to make a decision. She said that it had become clear that she had to change her behavior because her husband was unwilling to change his and that, in retrospect, her relationship with her husband had not been fulfilling even prior to his psychotic breakdown.

A week later, the husband's general physician phoned the clinic to admit him involuntarily. The GP reported that since his wife had left, the husband had not taken food or fluids and had become emaciated. Following a medical evaluation by a psychiatrist, who functioned in the professional therapeutic role of the Doctor, the husband was admitted involuntarily to the psychiatric unit. After receiving medication for three weeks, the husband's paranoid ideation slowly diminished. Following psychiatric stabilization, a therapist operating in the professional therapeutic roles of the Archaeologist and the Teacher, initiated individual therapy. The therapist explained that he would work with the husband to help him understand long-standing underlying problems that may have been out of his awareness and to assist him in reorganizing his life. In the interim, the wife successfully filed for a divorce. In retrospect, professionals who had adopted Mediator roles acted in ways to protect themselves and their professions rather than taking necessary risks to treat the husband's profound mental illness. These impotent responses served to perpetuate the husband's illness, promote the wife's distorted thinking and create a family system characterized by helplessness and hopelessness. By demonstrating ethical responsibilities to place client welfare before personal desires and by skillfully adopting

multiple professional therapeutic roles, therapists helped the husband and wife to achieve realistic solutions consistent with the severity of presenting problems.

Case 2: Saving the Hero

In this case the Shake-Up consisted of using the professional therapeutic roles of Detective, Archaeologist, Bird Watcher and Savior.

A general practitioner admitted an African expatriate (Mr. Y) to the psychiatric clinic of a center for people seeking asylum. He was a strong man in his mid-fifties. His balding head revealed several long and deep scars, the result of blows from sticks and rifle stocks from beatings received by soldiers in his native country. Accompanied by his wife, the man presented with psychotic features. He was initially treated with anti-psychotic medications and placed in both group and couples therapy, first in a day hospital and later in an outpatient clinic.

In couple's therapy, Mr. and Mrs. Y reported that they had supported high-ranking army officers, who plotted to overthrow the military dictatorship in their country of origin. The couple shared that several of their friends, who had participated in the coup attempt, had been betrayed and killed by army officers. Mrs. Y said that when government soldiers captured her husband, they imprisoned and tortured him daily because they thought he knew the identities of others who had participated in the failed coup attempt. She said that one day the soldiers hit him so hard that he lost consciousness and had to be hospitalized.

Mrs. Y reported that, through bribery and political connections, friends had succeeded in getting her husband out of the hospital and had lodged him in a safe house until he could be smuggled out of the country. She said that after several weeks, she was able to secure passage to the same country where her husband waited. In the interim their son was reportedly sent to England, but their daughter had reportedly "disappeared" when the soldiers came to arrest her husband.

Mr. Y said that he had studied in London and opened a business in his home country where he had been well respected. After providing a brief history of his marriage, career, and political activities, Mr. Y abruptly ended the conversation and stared blankly at the floor. In a monotone, he said that he had experienced many problems over the last year. Mr. Y said that he had initially suffered from symptoms connected to his traumatic experiences and that, more recently, his memory and ability to concentrate had become impaired. However, Mr. Y said that his greatest concern surrounded his inability to obtain asylum because immigration officers had not believed his story. Although he reportedly received a small monthly stipend and was permitted to live in a state-subsidized housing project, he said that he was not permitted to work or to build a new life. Mr. Y said that the stress resulting from

these circumstances had caused him to become despondent and had resulted in his mental illness. Upon hearing Mr. Y's report, the therapist concluded that helping the couple to obtain asylum and opportunities to pursue employment and stability in a new country would be critical goals in Mr. Y's treatment plan. However, the therapist felt initially compelled to inform Mr. and Mrs. Y that it was not in his power to help them achieve these goals. His role was to be the Doctor; he could not save their lives.

Mr. and Mrs. Y asked if the therapist would be willing to speak with their lawyer. The therapist agreed. The attorney shared his belief with the therapist that the couple had not been treated fairly by immigration officers, who had made the initial negative asylum decision. However, the attorney indicated that immigration officers had been compelled to make this decision because they had contacted government officials in Mr. Y's country of origin and had been told that he was not a citizen of that country. Based upon all available facts, the attorney said that returning Mr. and Mrs. Y to their home country would probably result in their torture and death. The attorney added that in order to grant asylum, government officials would have to acknowledge that the officials in Mr. Y's home country had lied to them. He indicated that this would be an extremely sensitive matter and difficult decision because government officials in the two countries enjoyed amicable relations. The attorney ended the conversation by indicating that these dynamics were responsible for the delay in a final asylum decision for Mr. and Mrs. Y.

After receiving this information, I realized that I could not accept this situation and stay out of the conflict. As a psychiatrist, I shifted out of my Doctor role and into the professional therapeutic role of the Savior. I also had to assume the therapeutic the role of the Detective because I could not resist making additional inquiries about the life of Mr. Y. I have to admit that reports of the governmental institute created skepticism about the story Mr. Y had told me. I really was in a loyalty conflict: believing my clients meant I had to admit that my government was lying. As I learned later from another similar case, this is a common problem when one adopts the role of Savior, especially with immigrants.

During the process, I had the luck of working with three very experienced therapists, two from the USA and one from Finland, who came to my clinic to exchange knowledge and conduct research about refugee and immigrant families (Ellenwood, Snyders, Poignon, & Roberts, 2006; Ellenwood, Brok, & Cornish, 2004). I asked them to participate in a consultation session with the couple and myself. The couple agreed heartily. The consultants assumed the professional therapeutic role of Journalist and asked Mr. Y to tell his story. During this session, the team observed from behind a one-way mirror and asked Mr. Y if he considered himself to be a hero. Mr. Y replied that he never had thought about this. Suddenly, he started to cry. He said that he

would have never done what he did if he would have known the consequences for him and his family. "So" he said, "I am not a hero." He saw himself as someone who had brought a lot of suffering to the people he loved and felt guilty about that. The team discussed if this was not always the case with heroes. They asked him to think about this and to try to see himself more positively. Team members told Mr. Y that, in their country, he would be considered a hero. For the first time Mr. Y sat up, looked alive, and his depression seemed to have lifted.

The team also concluded that the traumatic events experienced by Mr. and Mrs. Y in their homeland were now less important than the long lasting (more than 4 years) uncertainty about their safety and opportunities to build a new life in their adopted country. It was as if time had stood still for them and they were in an encapsulated state: they did not belong in either their adopted country or their homeland. Team members were aware of the fact that the longer Mr. and Mrs. Y experienced this "no man's land" phenomenon, the more difficult a new start would be. Team members later reported that they believed information provided by Mr. and Mrs. Y to be truthful and that they never suspected them of dishonesty.

The team suggested that adopting the professional therapeutic role of the Savior could be appropriate and effective in this case. However, I made it clear to team members that I did not have the power required to make changes in the clients' lives. I also had to be very careful in assuming the role of the Savior not to assume the professional therapeutic role of Superman. This would have been a natural inclination because of my knowledge about the adopted country. In addition, I had to be careful not to overwhelm the couple with my desire to "save" them. My primary goal in supporting the couple during these difficult times was to offer group and couple's therapy designed to help them deal with forces beyond their control.

After speaking to the group of international family therapists, I decided to believe Mr. Y and to cease functioning in the professional therapeutic role of the Detective. I wrote a long report to the decision making institute at the immigration office and stressed the brain damage that Mr. Y had suffered during his beatings while in prison. I wrote that it was of great importance to end this deadlock and that I had never had the idea that Mr. and Mrs. Y were not telling the truth. So, I had left my comfort zone and taken a non-neutral stance in this case. During this period, Mr. Y recovered very well from his psychotic breakdown and never relapsed. However, his neurological assessment confirmed extensive brain damage.

After some time, Mr. and Mrs. Y appeared in court for their case against the state. I went to the hearing with the lawyer who had invited me. During the hearing the lawyer for the state testified that I had reported that a Dr. B had made certain statements about the family. However, the information reported was erroneous. In

short, the lawyer was lying. I responded by saying in a loud voice from where I sat, "Your Honor, this man is lying. I never said such a thing and I can know this as I am Dr. B." In taking this action, I went quite far in my professional therapeutic role as the Savior. The judge responded to my comments by saying that I was not allowed to speak and if I did it one more time, the police would remove me from the court. The hearing went on. Looking back on this situation, I may have better served my patients (and myself) by instead having adopted the therapeutic professional role of the Bird Watcher.

During the first therapeutic session after the hearing, the couple asked if they could bring a video for mutual review during the following session. So, I brought a recorder. They told me that they now trusted me enough to show this tape. They showed me a video made at the funeral of Mr. Y's father some years before they had fled their home country. The video included images of Mr. and Mrs. Y and their two children. Both started to cry as they talked about their daughter. Mr. and Mrs. Y said that they had received no word about her since the soldiers came to their home and she disappeared. In observing their reactions during the videotape review, it became clear that their daughter's disappearance and probable demise had been such a painful episode in their lives that Mr. and Mrs. Y could barely bring themselves to talk about her. Other images on the video revealed that the family had been quite wealthy in their homeland. I was deeply touched by this video and by the fact Mr. and Mrs. Y had trusted me enough to share it.

I asked Mr. and Mrs. Y if they had shown this video recording to the government officials responsible for making a decision about their asylum. They told me they showed it to no one, not even to the lawyer. When I asked why they had not, Mr. Y said, "Doctor, do you think I should abuse the funeral of my father to prove that I am not a liar to people who are so dishonest to me?" Two month later the couple were granted asylum and were also permitted to apply for a passport. With this new status, Mr. and Mrs. Y were able to seek employment and, eventually, buy a small home. Our hospital staff helped Mr. Y to apply for training to become a security man. He could no longer work in his former occupation as a highly educated economist because of his brain damage. He finished his studies and was hired. Mrs. Y found work at a shop near their home. I saw them once a month to manage Mr. Y's medication, having reassumed the professional therapeutic role of the Doctor.

About six months later, Mr. and Mrs. Y again asked me to help them. They told me that they wanted their 15 year-old son to come and live with them. Immigration officials had reportedly denied his application to immigrate to the parents' adopted homeland because they had not visited him during the previous five-year period (a

requirement for immigration). Sadly, these officials had failed to consider the fact that his parents could not leave the country because they had no passports!

In response to their dilemma, I stepped back in to my professional therapeutic role of the Savior and again wrote a report for their attorney and for immigration officials. One month later, the couple and their lawyer participated in a mandatory hearing with a high-ranking official from the asylum institute. To this meeting, Mr. and Mrs. Y were allowed to bring a Doctor to support them. So, I attended the hearing.

The hearing was conducted by two women, who treated Mr. and Mrs. Y as if they were criminals. The officials asked Mr. and Mrs. Y how they had shown interest in their son over the last few years. They answered they had phoned him regularly and had sent some money to him every month. One of the interviewers then asked, "And, two years ago how much did you send to your son?" Mr. Y became confused. He could not remember exactly how much money he had sent because of the stress and memory problems he experienced at that time. Once again, I could not remain silent and asked the interviewer if she had read my report about Mr. Y's brain damage and related problems. The interviewer became very angry and told me to "shut up." She sternly informed me that I was not allowed to speak unless she asked me to do so. Again, I had overstepped a boundary in my professional therapeutic role of the Savior.

The interview proceeded in a very unpleasant manner. At the end, one of the interviewers asked me if I wanted to ask a question or make a statement. I told her that I had just one important question for her. She agreed to answer me. I asked, "Mrs. X, do you remember the precise date on which you changed from a human being into a robot without any empathy"?

We were asked to leave the room without an answer. In retrospect, I do not know if I did the right thing in my role as the Savior. I may have harmed Mr. and Mrs. Y's chances of getting their son in my desire to protect them from the verbal assaults of the interviewers. Clearly, I was unable to remain emotionally detached from the situation. Once again, I may have better served my patients' needs by having assumed the therapeutic professional role of the Bird Watcher.

In the end, the son was denied an opportunity to join his parents. During the application process, the son had turned sixteen and, according to immigration officials, was old enough to take care of himself. Through this case example, readers will hopefully understand that adopting the professional therapeutic role of the Savior is often fraught with difficulties and painful decisions. No matter how hard the Savior may work to protect clients, s/he may not always be most successful.

Shortly after the hearing, I once again adopted the professional therapeutic role of the Doctor for a brief period. In this role, I ceased writing prescriptions for Mr. Y and terminated therapy. Mr. Y was never readmitted to our clinic.

Case 3: The Family Box

The following case illustrates the technique of indirect consultation, which is used in the Shake-UP along with the professional therapeutic roles of Doctor, Detective, Archaeologist, Bird Watcher and Savior.

I was working as head of a psychiatric unit with inpatient, day clinical and outpatient treatment options. The hospital served patients who required long-term care, including life long care. The hospital served our own patients as well as those from other facilities who were not well enough to return home.

One day the hospital admitted a woman in her twenties, who was attractive, intelligent, and married with two small children. She had been treated for two years in a University clinic without making progress. The therapeutic team from another hospital had decided to refer her to our hospital for extended treatment or even life-long stay as all possibilities for curing her had been exhausted.

Before she arrived at the hospital, we had received an extensive report regarding therapeutic methods applied, medications used and treatment resistant hypotheses. The diagnosis was melancholia. The therapeutic team reported that every kind of anti-depressant and antipsychotic medication had been prescribed and that electroconvulsive therapy had been employed, all to no avail.

The patient's story was very dramatic. Not long after the birth of her second child, the patient reportedly became depressed. Outpatient care was not effective. Her situation deteriorated severely and she was sent to the University clinic where she was hospitalized for two years. In the absence of therapeutic progress, the patient was transferred to our hospital.

I will never forget the first meeting that I held with the head nurse of our psychiatric unit and the client. The client came to the session with her husband, who reported feeling very sad and hopeless at the prospect that his wife might be hospitalized for the rest of her life. She looked at me as if she looked straight through me. No contact. She repeated the same sentence over and over while wringing her hands and walking up and down the small room. "I am dead, I do not know anything anymore, and I am dead." She was experiencing heightened desperation. "And so young," I thought, "good looking and talented…what a waste…what a shame." The husband noticed how overwhelmed I was by the gravity of his wife's illness. "She has been like this for two years" he said. "It is so painful for me and all of us." By this statement, he meant their children as well as his wife's family that included five brothers and

sisters. "They help me a lot with the children" he continued. "I understand she has to stay here in the hospital for a long, long time?" Then he looked around. Luckily our ward had been built only two years earlier and was very nice and cozy. The units were designed for just 9 patients to live in a group environment. There were five one-person bedrooms and two double rooms all with large terraces surrounded by trees and flowers. We were very proud of our ward. Despite these pleasant amenities, the husband shivered at the thought that his wife had to stay here, all alone, and far from home. I did not want to share that the long-term units were still quite old fashioned with less privacy. We placed her in this unit so we could assess which ward was the best fit for her.

"Are you sure nothing can be done to cure my wife?" he asked and looked at me with the last hope in his eyes even as she continued to wring her hands and seemed oblivious of our presence.

I remember feeling very sad at that moment as the couple was just a few years younger than I. Unconsciously, I slipped into the professional therapeutic role of the Savior. I ignored recommendations provided by the psychiatrist and therapeutic team at the university clinic who advised that the wife be placed on a quiet ward to live out her life in peace. I told the husband, "If you agree, I will keep your wife on our admission ward for three months and try to find a way to help her. However, it is important for you to understand that we are working here from a family oriented perspective and we will need the help of all family members. Do you think they are available and willing to participate?" He thought. "I hope so," he said. "Everybody has been so involved for such a long time. But I will ask them." I told the husband that I wanted to schedule a family session as soon as possible, if necessary after working hours. We brought his wife to the ward and she did not even notice her husband, who was near tears.

The husband phoned the next day and an appointment was made for a family session. The entire family came to the session, including the wife's siblings and their partners, as well as the husband. Family members communicated an eagerness to be involved in therapy. Several members commented that this was the first time a therapist had invited them to a family session.

Note: family therapy was not yet popular in those days.

I immediately adopted the professional therapeutic roles of the Archaeologist and the Detective. Adopting the Doctor role was unnecessary because the two-year treatment at the university clinic focused on patient symptoms. When a family member raised the issue of symptomatology, I said, "That road has been travelled on for two years, let us try to find new roads and a connection."

In these roles, I worked to obtain information about the history of the wife's family of origin. However, gathering this information proved to be a difficult task because the client was unable to focus and frequently disturbed the conversation. Nevertheless, I refused to have a session without her. During this investigative process some very important information was revealed about the death of the patient's mother. The mother had reportedly died one year before the onset of the patient's depression and her death reportedly affected the patient, the youngest sibling, more than her brothers and sisters. The father had died many years earlier and the patient reportedly had the strongest emotional connection to the mother. As we completed four more sessions around the family history it became clear that the mother played a very important role in the family. Whenever there were conflicts between family members, she found a solution. It was also reported that when a family member experienced difficulties, he or she always went to the mother for advice. So, the mother served as an important "connector" for this family.

The mother's death reportedly had a huge impact on the family. Hidden conflicts emerged and were not amenable to resolutions. As a result, more and more emotional distance was created between the siblings. Prior to the mother's death, family members reportedly celebrated holidays together but now that rarely happened. Notably, family members agreed that their sister's illness had brought them together again.

However true this might have been, knowing all of this information and speaking openly about it had absolutely no influence on the patient's behavior. She did not speak during therapy sessions other than whining occasionally. Members of the unit treatment team discussed the case many times, but after five weeks we had made no progress and felt very stuck.

Then a very important thing happened to me. I had applied to attend international family therapy training with Maurizio Andolfi in Rome and was accepted. As a result, I had to leave my hospital for five weeks. Professor Andolfi had asked the members of his course to bring a videotape of a case that might benefit from a consultation. I asked the patient's family if they would allow me to take a video of their case, to which they readily agreed. I eventually compiled video recordings of five sessions, which was a lot of work!

In Rome, Professor Andolfi did indeed recommend a very strong intervention for me. When I showed the tape to him and the eleven other group members, he looked at it for about seven minutes. Then he asked me to stop the tape because he had "seen enough." Then he said to us, "First, I want to thank L. for having the courage to bring us a tape of a family session that has no use." All of us felt uncomfortable at that moment, especially me. Then Professor Andolfi said he wanted to do a short role-play. I had to be the therapist, while others played the patient and the family

members. He asked me to say as therapist, "Blablabla," then for the patient had to say, "whoohoohoo," while all others in the session were instructed to bow their heads. We were directed to engage in this activity for five minutes (which seemed five hours). Then the consultation was over and Professor Andolfi asked if another member of the group had a video to show. I have to admit that my warm feelings towards Maurizio Andolfi cooled down a bit that day. (However, they changed again later as the training continued).

I returned to the hospital full of creative thoughts and energy. The patient was still whining and wringing her hands all day. She followed the day program but this appeared to have little influence on altering her behavior or resolving her symptoms. I had thought deeply about the case after the consultation with Professor Andolfi. It was clear to me I had to address her behavior in a much more forceful way. I re-examined and retained my hypothesis that the death of the patient's mother was very important precursor to her symptoms and behaviors. My idea was that the patient had tried to fill the gap in the family that was created by her mother's death. She had tried to become the conflict manager and family healer, but had failed in these roles because they were too great for the youngest sibling. That, I surmised, was why she felt so guilty and powerless; it was as if she were as dead as her mother.

I organized another session with family members, who were very curious about the results of the training with Professor Andolfi and with whom I had reviewed their taped therapy sessions. I told them that I had learned a great deal and that I had thought deeply about their situation. I then announced that I had a very important task for all of them. I wanted the patient to make a wooden letterbox with a slot in the creative therapy sessions that she attended twice a week. Every family member would be required to write down all of the conflicts that he or she had with another family member on a piece of paper and to slip it into the box, which would be placed in the patient's room on a special table. Everybody agreed, even the patient who had listened carefully to me assigning the task.

The next day, an incredible thing happened. The patient started to make her box. She worked on it very enthusiastically and seriously. She decorated it and made a nice slot in the top of the box. After two weeks she had finished it. The creative therapist told me he had never seen the patient work so devotedly on any previous project. Proudly, the patient placed the box on a special table in her room so that her family members could place their letters in it when they came to visit her. But after three weeks *nobody* had put a letter in her box! The patient looked very worried and sad. Her whining became worse. I wanted a session with the family to discuss these circumstances. However, before I could schedule it the patient disappeared. She went for a walk and when she did not return for dinner or the night, we started to worry.

We started a search and found her the next morning, unconscious, in a little forest on the hospital grounds. We immediately phoned the family.

We brought her to our medical unit and treated her as if she had overdosed on medication. At the unit, she was stabilized but remained unconscious. The family arrived about five o' clock p.m. as I was sitting in my upstairs' office. When I came down the staircase, family members started to shout, "Murderer, murderer!" I felt terrible and tried to remain calm. I told them that the patient was stable and that I wanted to have a session with them immediately to discuss what had happened. Although they initially said that they never wanted to speak with me again, their anger and fears eventually abated. After a half hour, family members said that they wanted to have some food first and then they would be willing to have the session. I organized a big room in the hospital and asked a colleague psychotherapist and three nurses to assist me with the session. We set up a video recorder in order to tape the session.

We brought the patient, still unconscious, to the therapy room on a bed along with her empty box. The session took three hours and was very dramatic. I started to tell the family my hypothesis: that their sister unconsciously took the role of their dead mother. She tried, like her mother to solve the many family conflicts, but had failed. I told them that I wanted them, one after another, to sit beside her and to speak through her to the dead mother about conflicts they have had with other family members and fantasize about possible solutions for the conflicts.

I placed the box on the belly of the unconscious patient and asked all the family members if they had pictures of the mother with them. Surprisingly, all they did! I collected the pictures and put them on the body of the still sleeping patient. Then everybody spoke, honestly and with full emotion about their conflicts, which was motivated by the emotionally strong context. I adopted the professional therapeutic role of the Bird Watcher and simply supported the speakers (most of whom were sobbing), inviting the next speaker when one was ready. After everybody had spoken, I thanked all for their courage, hard work, and trust in our team, even in these difficult circumstances. Family members then went home.

The next day the patient woke up and told us she felt much better. She did not whine or wring her hands. She told us she had gotten to the point where she had felt totally worthless and had taken sleeping pills and walked to the forest to die. Team members and I asked her if she remembered the family session from yesterday. She said she had been half asleep but had experienced some of it without exactly hearing what everybody said.

The patient's husband came to visit her and was thoroughly surprised. After two days, they asked for a session with me and told me that the wife wanted to go home

and restart her life. I felt a bit insecure and told them that I preferred a weekend visit with a return to the unit to discuss their experience. They agreed, returned to the unit the following Monday in high spirits, and reported that they had experienced no problems. They again proposed that I should send her home. I agreed, but told them that they could return at any time if necessary. Two weeks later we had a follow up meeting, during which the couple reported that all was going well in their lives. We terminated therapy and all medications.

In retrospect, this very dramatic case taught me that adopting the role of Savior is sometimes necessary to cope with earlier unsuccessful treatments. You may even need to seduce others in to assuming the professional role of the Savior as I had done with the head nurse. However in severe cases, we are compelled to take risks. In this case, adoption of a more active and robust professional therapeutic role was necessary. The therapist needed to develop very powerful interventions to bring change to a very resistant family system. However, one must be cautious because the use of such interventions can be risky (e.g., in very rigid systems the outcome is not predictable).

In the final analysis, we must accept the fact that interventions designed for family systems will often be very complex. We will perhaps never succeed in creating protocol-led treatment plans with easy to predict results. However, choosing to not use these powerful, family-oriented tools because they are complex and unpredictable is like "throwing away the child with the bathwater," as we say in Holland.

Reflections of the Authors

Without a doubt the writing of the **Shake-UP** changed our thinking, our creative ways of exploring our life teachings, our interactions with others, our families and our very own professional therapeutic roles in which we engage each and every day. We hope that through studying this book, a process was presented to you that helped you to self-reflect and find those professional therapeutic roles, techniques and tools that will guide you gently and quickly out of an impasse no matter who the client or what the presenting concern may be.

Chapter 26

While writing this book, Stacey Lynn Osborn, Initial Editor, suggested that the authors prepare a "Self Reflection" and share it with you. She thought this would provide insight into our thinking and the development of the book. As we worked, it became clear that writing a self-reflection would not be a simple task. We are sharing our reflections here in chapter two so that you can become aware of our struggles as we evolved and will set the stage for your self-reflection as you progress through the book.

Although our preferred professional therapeutic roles were reasonably simple to identify, less simple was to understand how these professional therapeutic roles developed from our roles in our (extended) families of origin, school experiences, social networks, sports clubs, university and family therapy training programs, work settings and circle of current friends. The following content reflects how each author, Audrey Ellenwood- further named Audrey, and Lars Brok, further named Lars, developed their own set of preferred professional therapeutic roles and how they changed through time as well as through the process of writing this book.

Audrey Ellenwood: Angel, Savior, Teacher, Doctor

When the book was in its infancy Lars asked me, "What do you see as your preferred professional therapeutic role?" Without hesitation I said, "I am an Angel, a Savior, a Teacher, and a Doctor. As we began to speak and write about Vincenzo Di Nicola's *"living culture"* concept I began to think upon the people who were most influential in my development and began to envision the roles I assumed with family, peers, in social circles, and in school. In my family of origin, I was the listener and the child who could do no wrong. I always saw the positive side and tried to help everyone. In hindsight, perhaps I was not as helpful as I thought. Without a doubt my "living culture" was touched deeply by my mother, father, and two siblings.

My dearest junior high and high school friends (the "Illing" gang) and my "Bestest buddies" (Dave Fox and Tim Gurske) clearly helped to shape my interest in becoming a therapist when I was in junior high school. During that period, I was not too excited about school and was definitely more interested in "boys," what I was going to wear to school, and going to the *Teen Center* on Saturday night than I was in studying. But as I look back at each year of school there was always a teacher encouraging me to study more.

Throughout my life, friends would approach me and talk at length about personal issues or concerns and I would always say but…. and bring in the bright side of life-thus the *Angel* was born. When I was in high school, two significant events shaped my life. First, I spent some time tutoring underprivileged children in an inner city school and that is when the *Teacher* entered the scene; second, I went to Europe with my parents and my love for travel, curiosity about other cultures, and desire to succeed became engrained. I returned home and went from a D and F student to producing A's.

I entered university with the goal of becoming a teacher, but a psychology professor kept encouraging me to think about pursuing studies in that discipline. So, I combined the two and became a school psychologist. In 1987, after graduating with a Ph.D. and while studying for the national psychology licensure exam, I was involved in a serious head-on auto collision while traveling to Chicago and experienced a mild head injury. During treatment for this injury, I came into contact with Donald Cameron, a neurologist. It was the luckiest day in my life for he had a major influence on shaping my career and professional practice. I went on to study neuropsychology, learned to administer and interpret various neuropsychological assessments, worked on teams that created various hospital clinics for neurological conditions (e.g., neonatal, attention deficit disorders, mild head injuries, autism, and seizure disorders) and provided workshops on various neuropsychological topics related to children. Hence the *Doctor* was born.

In 1991, I met Maurizio Andolfi, World Renowned Family Therapist, and fell in love with the art of family therapy. I began to write on the therapeutic process and my university teaching became very culturally based. I began to provide trainings for students with Professor Fredrick (Ricky) Snyders at the University of South Africa. In the process I grew to love South Africa and began to recognize the impact of AIDS on children in townships from an educational standpoint. In my role as Savior, I developed a 501(c)(3) charity for children in South Africa, Project Learning Around the World (www.platw.org).

Through my connection and training with Maurizio Andolfi, Rick Snyders, Vincenzo Di Nicola, the entire Andolfi family (therapists from around the world) and particularly with Lars, my co-author, my guiding light was ignited and I began to incorporate many of their ideas into my private practice work with clients. Since writing this book, I now see how my "living culture" and life experiences helped to shape me into the therapist that I am today, *or was,* until the writing of this book…

The Standard Ho Hum Me

When Lars and I began to identify and flesh out the professional therapeutic roles identified in this book, I sat back and studied myself as I worked with clients. In doing so, I noticed that the professional therapeutic roles we were writing about came alive within the session. I began to realize how much hope I projected onto my clients and how quickly I would pull out the blackboard and begin to "educate" them on one topic after the next. I was quick to refer them to other educational resources and astutely realized how many of my assigned therapeutic tasks and techniques used in the session were based on "teaching". As soon as clients entered the session with neurological issues, I became the Angel, the Teacher, and Doctor all at once. I now realize that, in these professional therapeutic roles, I safely connected to clients but also kept a good distance from their emotions. This was a very safe place for me as a person and as a therapist. Without a doubt these were my preferred unconscious professional therapeutic styles and the ones that I depended on almost exclusively. For the most part, I was very successful with clients. However, as I began writing this book I thought about clients that came for only one or two sessions and I now wonder if it was my preferred professional therapeutic style that contributed to their not returning? Were we actually at an impasse? And, yes, I was quick to apply the psychoanalytical notion that the problem (i.e., resistance) resided squarely within "clients" and, of course, not me. I now realize that my rigid adherence to a preferred professional therapeutic role may have created impasses that led to some early terminations.

A New Awakening

As mentioned earlier, the professional therapeutic roles described in this book began to come alive for me as each was developed and I could actually envision each of them as I experienced them. The picture in my head depicting each professional therapeutic role was humorous and I often laughed to myself. I am now quicker to pick up on a clients' seduction and am more flexible shifting from one professional therapeutic role to the next. I am amazed by how my approach to clients has changed. I no longer sit and make self-statements similar to those in chapter 23. Rather I begin to think… *hold on, what is going on here… and where do I need to go*. Upon meeting clients, I no longer have a preferred professional therapeutic approach. I wait to determine the presenting issue and then activate the professional therapeutic role I think will be most effective. I find myself shifting more into the professional therapeutic roles of the Detective, the Journalist, and the Archaeologist once a relationship has been established and the presenting issues have been addressed through the application of another professional therapeutic role. I am, without doubt, a

different therapist. I listen, attend to verbal and nonverbal communications, expand information to create several hypotheses using the funnel approach, and visualize professional therapeutic roles better suited for each client's presenting typology. In my mind's eye, I actually "see" professional therapeutic roles being played out in the session. The therapeutic techniques and tasks that I now apply have become varied and are more effective at creating structural changes for the clients which lead to lasting change for them.

By writing this book, I have observed that these professional therapeutic roles have not only become flexible in my practice but also in my everyday life. I frequently stop and say, "Oh my, you are in the… role in this situation" and I can either shift out of that role or keep it. As an author, a therapist, a professor, a wife, a mother, a grandmother, a sibling, a friend, a member and leader of various professional organizations, I now have a new outlook on life. I am no longer the Savior, the Teacher, or the Doctor. I am… who I am… when I need to be.

Lars Brok: Clown, Doctor, Teacher, Savior

To become conscious of (an important) part of your "living culture," you need a lot of self-reflection, possibly therapy, and reflective talking with family members, friends, colleagues etc. The process is not always simple and *it* takes a lot of courage.

Based on information from important people in my life and my self-reflection, which included years of therapy and looking back at many videotaped sessions with clients, I can say that I have become able to use a number of the professional therapeutic roles in quite flexible and interwoven ways. The roles of the Archaeologist, the Teacher, the Doctor, the Angel, the Journalist and the Clown now appear to be my preferred professional therapeutic roles. Sometimes I may even adopt the professional therapeutic roles of the Construction worker, the Detective, or the Savior. I am fully aware that my preferred professional therapeutic role when I am in trouble and do not know what to do is the professional therapeutic role of the Teacher. Looking back at my tapes I see myself talking and talking to the members of the family, hoping they will understand what I think they *should* do. The other role I use when in trouble is the role of the Doctor. This is especially true when one of the clients presents him/herself with severe psychiatric symptoms or when the family puts a lot of pressure on me to see the problem as a disease. I often find myself prescribing medication even when I am not convinced that it will be of any use and/or starting a program of psycho-education instead of having the courage to explore the deeper roots of the problems or redefine the problems.

I cannot deny that the professional therapeutic role that fits me the best and is also more effective and satisfying for me is the Clown, in the broad sense of the

word. Mostly, I choose the comedian aspect of the role to help create chaos in the family. Looking back it is the role I assumed in my family of origin and later on in many social, school environment, and workplace contexts.

I was the youngest child in my family. My sister, who was perfect in everything, even as a sister, was five years older. To create a place of my own within my family and to distinguish myself I chose, unconsciously, to become the Clown. I used this role in order to become an interested observer, who liked to comment about what he saw in a friendly, but provocative, way to others. My mother a humorous and provocative person also used this role herself. So as I reflect back, I see I copied her behavior. In high school I was always the smallest boy and the teachers had me skip a class in primary school. I often used humor to protect myself. The role of the Clown was so effective that I used it at the university level and with my friends. I now use humor *not* to protect myself but rather to impress others.

One thing I have never understood, since I was fifteen years of age is that I absolutely wanted to become a psychiatrist. I cannot connect this desire to any event that I can remember. No psychiatric patients in my family, no traumatic events as far as I know. I wonder if something happened that I kept unconscious. Who knows? I only know that when asked about the future, I would say that I wanted to be a psychiatrist. Many times I was teased about this answer but for me, it was just a fact. Strange!

My medical training forced me more and more into the role of a serious doctor. My role of the Clown and the creativity that accompanies this role were forced to the background. Somewhere in my professional training, I decided to participate in intensive psychodrama training. From Dean and Doreen Elefthery, trainers, I learned to balance the role of the Doctor, the Clown, the Journalist and the Archaeologist. As director of the psychodrama you had to be creative but you needed to check constantly if your ideas fit into clients' views and experiences.

When I began my psychiatric training, I again pushed the role of the Clown far away. Working as a young psychiatrist in a psychiatric center (with a lot of responsibility for several wards full of patients and with not much experience in leading teams of psychiatric nurses and psychologists the professional roles of the Doctor, the Construction worker, the Teacher and sometimes the Superman were brought to the foreground. The strong pressure of the psychiatric nursing team to play the role of the "all knowing" Doctor when I had no experience at all, suppressed the role of the Clown. Looking at psychiatric problems from a different, systemic perspective was not permitted. Other professionals perceived listening to information provided by family members as insane. Changing rigid patterns of relating to patients on the wards (especially the long stay ward) brought forward enormous resistance in the psychiatric nursing team. I varied my professional roles from that of the Savior

with patients to the roles of the Superman and the Teacher with the professional teams. But, it did not work. I found that implementing the professional roles of the Journalist and the Archaeologist, with a bit of the Angel in the whole ward system, worked better. I tried to gather information in an effort to understand why and how the interactional patterns between psychiatric nurses and patients had developed. Further, how the rules of the ward and also the bigger context had supported these interactions. In the mean time I played the professional role of the Doctor when necessary. Only under pressure did I fall back on the professional roles of the Savior or the Superman. Looking back it is apparent that both of these professional roles always led to impasses and sometimes to real "wars."

Meanwhile, I continued my family therapy training and the new information helped me to refrain from using the inadequate professional therapeutic roles of the Superman, the Savior, or even the Referee.

I was so lucky to find at my workplace a colleague and family therapist, Rick Pluut, with whom I worked as a therapeutic team for more than 12 years. Together we started a family training institute, ISSOOH, which is still in existence. For more than twenty years we trained family therapists. He often interviened "on-the-spot" from behind the one-way mirror with an intense demeanor whenever there was an impasse in family sessions. He was a genius in pointing out the professional therapeutic roles I had taken and he effectively changed the professional therapeutic role by developing strong interventions from the stand-up comedian (Clown) role that he liked to take. He shocked me many times, but he was of immeasurable value to me (See case examples in chapter 2 and 11).

As the years passed, I gained experience, and succeeded in inviting whole families to sessions. In these family sessions I experimented with the roles of the Construction Worker, the Teacher, the Journalist and the Archaeologist. However, the professional therapeutic role of the Clown was barely used.

During family therapy training my teachers, Max van Trommel, a man who was most of the time quite serious and preferred the professional roles of the Teacher, the Construction Worker and the Mediator, and Koos van der Meulen, a very warm but also serious social worker/family therapist, who preferred the roles of the Angel, the Mediator and the Teacher, told me to use more my creativity and the professional therapeutic role of the Clown (although they did not call it the Clown). I will never forget their remark, "You have to let go your horses inside. Do not always try to control and steer them. Trust their intuitive sense of where to go." And, here I thought I had already given them too much space! And the role of the Clown hesitantly returned to be present again.

At the end of my family therapy training I followed several workshops from Boscolo and Gianfranco Cecchin. They helped me to use the roles of the Journalist and the Archaeologist in a different way. The technique of circular questioning made it possible to introduce new visions on the problems and the relations in the family. They were comedians without humor (however, Gianfranco was a very humorous man!). Later Carl Tomm taught me even better how to use these techniques. Discussions behind the one-way mirror between members of the team resulted in the creation of very different hypotheses by the therapists and taught me how important the role of the therapist was in the therapeutic system. The danger of this kind of therapeutic method was that some therapists started to believe in their hypotheses and went on searching for proof of them in spite of contradictory feedback from the team. They became detectives who believed that somebody was guilty and went on and on trying to prove the hypothesis.

In reflecting about my preferred professional therapeutic roles, I have to say that I also loved the professional therapeutic role of the Angel. This role too is connected to my younger years. As a student it was always me who loved to cook for my friends, who opened my room for everybody and who loved to create harmony not by agreeing with others but by stressing how nice differences were. My family calls me, "The Feeder" as I love to encourage people eat lesser-known foods, which they expect not to like. I prepare and serve this food in a way that they start to like it. My fault is sometimes that I *overfeed* people. This also holds true when I am doing therapy as I try to help clients to enjoy their symptoms, show them their "tasteful" or "useful" sides. This is especially true when working with people who have psychotic experiences and their families (the client group that I prefer to work with). I try hard to interject hope. Sometimes too much hope! I remember well one of my very faithful clients who (in a group session) corrected me. "Lars," he said, "You make it all too nice and beautiful! You have to see and understand that I am suffering a lot from my symptoms and disease!" The other group members understood him well and they all started to show me the flipside of the coin. But they also admitted that they felt often helped by my redefinitions and "feeding." I now try to remember this lesson and stay closer to the professional therapeutic role of the Journalist. I work hard to listen in a neutral way and to refrain from too much redefinition.

In 1981 I made the very important decision to go to Rome, Italy, to follow a four-week international training in Family Therapy with Maurizio Andolfi and his colleagues. I was looking for a teacher who could help me to combine the creativity of psychodrama and working with families. The other group members were very experienced. Some had followed a long training period with Carl Whitaker, Carlos Sluzki, and with Paul Watzlawick. Some were already "old" and had even founded

family therapy in their own country. Again, I felt I was the "Youngest" and I took the role of the Clown again. Some of the group members became very important to me as colleagues, teachers, and even more as friends. In particular were Dr. Russell Haber (USA), Noga Rubinstein (Israel), Joel Elizur (Israel) and Esther Wanschura (Austria). We met regularly and often invited each other in our different countries to give workshops, teach, and have fun.

The training was very impressive (see case story two in chapter 25). My eyes were opened even more for the enormous importance of the person of the therapist and the role he takes in the therapeutic system. I became cognizant of how one's "living culture" steers the choice of a professional therapeutic role in the therapeutic system, particularly as it relates to the interplay with the culture of the family you are treating and the problems they present. Also critically important, but often more invisible, are the cultures of your workplace, "your therapist family," and the larger context of the health system and the culture in which you live as they influence your presenting culture in the family sessions.

In Rome, Maurizio Andolfi stressed the importance of creativity, and the professional therapeutic role of the Clown. Through my experience in Rome and interactions with my colleague Rick Pluut, who went to "Rome" two years later, I had a long period in which my preferred professional therapeutic roles were a combination of the Clown, the Archaeologist, and the Journalist. We carefully studied and analyzed the professional therapeutic roles of the therapist in the therapeutic system. It was my colleague, Rick Pluut who started to assign names to the professional roles such as Clown, Journalist etc. Therefore, while writing this book we acknowledge that a lot of credit goes to him! Rick Pluut and I invented, more or less, the techniques of intervening from behind the one-way mirror and "changing the role of the therapist as the main intervention in family therapy" as we called it in the workshops we gave around this topic. (see case example chapter 7).But I have to stress that it was Audrey who (while giving a family workshop with me about this topic at Bowling Green State University, Bowling Green, Ohio) fully understood the impact of the role concept and elaborated it to a workable tool for therapists, clinical training and supervision. It was during this workshop that the true conception of the *Shake-UP* started to develop.

Audrey pressed me to write this book with her. She took me by the hand and convinced me that the professional therapeutic role of the Teacher from a distance can be very effective too. I always had the strange idea that I needed families or trainees with me in the room to become effective, but now I know that I can change perspectives from afar. However, I still like face-to-face encounters and miss you, the readers, in my room.

Ever since, it has become clear to me that I always had to wrestle to find a good balance between the professional therapeutic roles of the Clown, the Archaeologist, the Angel and the Journalist versus the roles of the Doctor, the Teacher and the Savior. New research and knowledge in the psychiatric field, mainly concerning brain processes and functioning, stressed the importance of medication (professional therapeutic role of the Doctor), but also of cognitive therapy approaches and psycho-education (professional therapeutic role of the Teacher). This knowledge often created some doubt within as to my professional role and made me insecure, particularly in regard to clients who have tried to seduce me more and more into the professional therapeutic role of the Doctor. Luckily, for twenty-five years, every three years, Maurizio Andolfi provided a meta-practicum around a number of issues related to family therapy from his training groups in Rome. Within this group I found other important teachers/colleagues and friends who have influenced me a great deal; Jorma Piha (Finland), (Frederik) Ricky Snyders (South Africa) to mention two. Attending these meta-practica helped me to re-think the professional therapeutic roles and to discover the more ridged professional therapeutic roles that I often adopted (the Teacher, the Savior and the Doctor).

I now realize more than ever how important the professional therapeutic role of the Clown (comedian) can be in the therapeutic system. But also how difficult it can be to keep in touch with this creative part of oneself. Some people have said that you cannot learn this role. I disagree. Start with the more structured professional therapeutic roles of the Journalist, the Archaeologist or the Mediator and begin to use a variety of professional therapeutic techniques or tools especially metaphorical objects and metaphors when playing these roles. Ask your clients to bring metaphorical objects and use nonverbal techniques as drawing, family sculptures and music within sessions. These techniques and tools will lead you to unleash your creativity and bring out the professional therapeutic role of the Clown, who is a part of each and every one of us, as it is for me.

The Families and Shaping of Our Therapeutic Professional Roles

This brings us to the impact that the families we worked with had on the shaping of our preferred professional therapeutic roles. Some have been extremely important. In 1992 Maurizio Andolfi offered a meta-practicum in family therapy training in Elba, Italy, around the issue of working with families from different cultures. It is there where the authors met. During the meta-practicum we became very interested in working with families from different cultural backgrounds. After the practicum, we conducted research in Holland on the topic. During the process, we discussed in

depth which professional therapeutic roles would be the most efficient when working with refugee and immigrant families.

Individually and jointly, we worked with many refugee and immigrant families. The families taught us that the professional therapeutic roles of the Archaeologist and the Journalist were very effective. However, we also learned that we sometimes needed to take the professional therapeutic role of the Savior in order to support families in their struggle with the bureaucracy of the host country and often the harsh discrimination they encountered. Sometimes the professional therapeutic roles of the Secretary or the Bird Watcher were useful as we listened to their stories without interruption.

It became clear to us that in the professional therapeutic role of the Journalist, we were required to learn about the immigrant family's "Odyssey" or their journey toward the host country. In the professional therapeutic role of the Archaeologist, we investigated the nature of their lives abroad and in their homelands by using a variety of therapeutic tools such as pictures, drawings, and books. In this way we made the family the teacher and as we learned, we used the professional therapeutic roles of the Bird Watcher or the Secretary for some sessions. As a next step we started to discuss the here and now and the difficulties they experienced in the host-land. In this process, we regularly adopted the role of the Savior for example to guide them through the often long period of getting permission to stay in the host country. This role can be quite heavy but very effective when applied as necessary (see case three in chapter 25). By assuming alternately the professional therapeutic roles of the Journalist, the Archaeologist, the Secretary, the Bird Watcher and the Savior, true movement and positive change for the immigrant families occurred.

Lars discovered that in his therapies with psychotic clients and their families, he used a different combination of the professional therapeutic roles of the Archaeologist, the Journalist and also the Clown. The use of metaphorical objects and genograms were very helpful in shifting professional therapeutic roles and making changes within the families so that an impasse did not develop. For the patients who experienced traumatic events in life, creative therapy and psychomotor therapy, where the therapist takes the role of the Teacher, are excellent therapeutic tools.

When working with trainees, we always emphasize that a therapist must be aware, each and every session, that therapy sessions are very important experiences for clients. If you meet clients your age, you may begin to think of them as your brother or sister or partner. When your clients are older, you may think they are your father or mother. When meeting children, you may begin to think they are your children. You need to remind yourself of this, every time you start a session. It will prevent you from seeing the session as "routine" and will help you to avoid assuming

a rigid professional therapeutic role that will lead to an impasse. This reminder will help to keep your sessions fresh and alive!

To illustrate the importance of how our clients have helped to shape our professional therapeutic roles, we would like to end by sharing one last important case. We have learned it is important *not* to try to be as neutral as possible in the sessions. Rather, it is critical to open yourself to other members in the therapeutic system and to have the courage to allow the family to help you change your values, worldview, and prejudices when working together.

A request for admission from a general hospital for a young married woman with a child of nearly two years was made. She had been admitted to the general hospital because she had made a serious suicide attempt and had barely survived. Following treatment in the intensive care unit, she left her bed to go to the toilet and cut her two wrists and her tongue. The blood coming from under the door betrayed her actions and she was found, still alive. After surgery, hospital staff tied her to her bed and the psychiatrist of the general hospital wanted to admit her to a psychiatric hospital.

When a person was admitted to our hospital, we always asked significant others to accompany the patient to the ward for admission. So we invited the couple and other family members (brother of the patient and the mothers of patient and of her husband). In this case, just the couple came. In those days we conducted our sessions before a large one-way mirror. Behind it 15 people could be seated. The co -therapist and two or three psychiatric nurses of the ward always attended the sessions and were involved in the process and sometimes even in the session. Often visitors from other institutes attended the sessions to learn from our way of working as we were the only place in our country where family members were admitted in the ward and involved in the whole therapy process.

The patient was brought into the room by two strong psychiatric nurses dressed in white and was tied to a stretcher. She was an attractive young woman with both arms wrapped in large white casts. Her husband was about 25 years her senior and was bent over with a humpback. All of us were surprised and a bit intimidated by the appearance of the couple and the way the woman was tied up.

I immediately felt the enormous pressure from the referring person and the ambulance nurse to take the same professional therapeutic roles that they had used; the Firefighter and the Savior. They expected me to act as controlling as they had been towards the woman. But when I met the woman she made me decide not to step into those predictable and rigid roles. But I also realized that I took a risk by not doing it. I asked the woman what she wanted; to attend the session tied to the stretcher to help her to be safe against the destructive power within her or to be

untied and take a seat with her husband and me. After thinking a while she decided to sit with us. Her husband told us that he was frightened by the idea, but could accept it because I was there (trying to put me in the professional therapeutic roles of the Savior or the Firefighter). I told him that I had learned during my professional life that nobody could decide about the life of another and that we had to accept the choices his wife would make. One of the ambulance nurses told me that the woman had been tied to her bed for three days for security reasons as I started to untie the woman. He began to look at me if I was a very irresponsible doctor, and perhaps I was. However, I had decided not to be the Doctor, but first the Journalist and then as soon as possible the Archaeologist!

The psychiatric nurses left and the session started. As planned, I started with some journalistic questions about the last few weeks. It became clear that there was a very complex family problem that involved the woman's mother and, in another way, the mother of the husband. The woman said that she had tried to kill herself because of her intensive conflict with her mother about her daughter. She had the idea that her mother wanted to kill her daughter and that she could prevent this by killing herself so the daughter could live with the mother. I asked about the woman about cutting her tongue; I understood her wrist cutting but not the cutting of her tongue? She explained that, in case she did not succeed in killing herself she could try to make herself speechless so she could no longer disagree with her mother. Following these journalistic questions, we employed the therapeutic technique of the genogram, during which it was revealed that the husband, a famous musician had always been her piano teacher. He discussed his upbringing and how his mother always encouraged and supported him in a positive, but sometimes heavy-handed way. He spoke about the complex relations he and his wife had with her mother as she always had been strongly against the marriage of her daughter to a much older and crippled man. But the music had brought them together.

After the birth of the daughter, a miracle, he said, his wife's mother refused to come and see her granddaughter. A huge conflict arose and his wife became more and more convinced her mother would murder her daughter. "It is not true," the husband said. "Rather, it must be a psychotic idea". We spoke more about the history of both families and after an hour and a half I told them that I wanted to discuss reported information with the therapeutic team. So the couple waited in the room. The team decided to maintain the professional therapeutic role of Archaeologist and to ask the couple to teach us more about the family during the hospitalization period. We also decided that we had to rely on the strongest bond between the couple, which was the piano. We then decided to give the couple the task of composing a piece for the piano. They had to write a melody for every family member involved that "fit" the

character of each person. Then they asked to compose a piece of music with these melodies that could tell the story and problems of the family and how they thought they could resolve identified problems. To help them achieve these tasks, we offered the family a double room at our ward. They could decide together if they wanted to stay on the closed ward, with more security, or on the open ward. We also offered to bring a piano on the ward to use for their task.

You must understand that some of the team members were quite afraid to give away so much control. However, we convinced them that roles the therapists/doctors had taken in the general hospital were not working so we needed to take a different role and employ the therapeutic techniques of using metaphors.

I returned to the therapy room and explained our plan to the couple, who were surprised by our offer. The husband was very content that he could stay with his wife and both loved the idea of the composition. They chose the open ward. So we made a new appointment in three weeks. Our task was to cook food for them, give them a double room with clean beds, offer support when needed and to provide a piano. They could follow a day program consisting of psychomotor therapy and creative therapy, if they wanted. They just had to attend the daily group meetings with the other clients and psychiatric nurses on the ward.

Over the next three weeks the couple seemed to enjoy their stay on the ward. The daughter came regularly, with the husband's mother, to visit them. And they took their task very seriously. After three weeks, we had a session and the couple explained to us, as teachers, about how you tell something in "the language of music". I told them I was stupid and not knowledgeable in that realm, so they took time to teach me. Then they played the melody composed for every member of the family: her mother and his mother, her brother and then she and he. She explained carefully how they had determined the exact melody for each family member. They then together played the composition, each using one hand.

The wife could not use her other hand because she had unfortunately cut the nerves of that hand. Much later, the wound healed partially and she was able to play again. They also explained what they had written in their musical composition about the family problems and how to solve them.

Through this process, the couple decided to break relations with the mother of the wife for at least two years. We decided that it would be wise to invite the mother for a session with the couple and the team when they decided to resume contact. I offered to speak to the mother alone if she desired and six months later she made an appointment.

After the very moving and impressive session where three therapists and three psychiatric nurses listened to the composition, the couple told us that they had

decided to go home. They made a follow-up appointment after two weeks and continued in therapy for two months more. We asked the couple if we could use the tapes of their sessions for workshops and they happily consented. We have since shown these tapes during our training and at congresses and workshops to teach about the use of metaphors as well as the importance of the professional therapeutic roles chosen by the therapist.

Approximately six years later, while working in Rotterdam, the couple phoned me because they had reportedly experienced some problems. They wanted to come to me for some sessions and I agreed. I could not resist asking them what they thought had worked so well six years ago as they never again had any problems related to suicide or "psychosis." I reminded them about our use of the metaphor and the music. They surprised me when they said that they could not remember well the music part! However, the most important therapeutic experience for them had been the fact that we gave them back all responsibility and showed real interest in them. They also talked about how helpful the hospitality on the ward had been as well as the opportunities to speak about possible solutions while they were "pampered" and not "controlled." I then realized that change occurred for this couple because I took the risk of employing the professional therapeutic roles of the interested Journalist and the Archaeologist, in concert with an element of the Angel role, while they experienced genuine caring.

In retrospect, resisting the forces that wanted us to take the professional therapeutic roles of the Firefighter and the Savior had been the correct choice and made the difference. Adopting these expected professional therapeutic roles would likely have resulted in an impasse and possibly continued suicide attempts by the wife.

The story of these clients was shared so that you will learn to trust your ideas, your creativity, and that you possess the ability to risk a professional therapeutic role shake-UP. We also hope that when you experience an impasse, information gleaned from this book will help you to shift in and out of professional therapeutic roles and employ therapeutic techniques and tools that will be most effective in creating lasting change for your clients.

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Author Index

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Table One

Therapeutic Professional Roles

The Therapeutic Role	The Description	The Positive Use of Role	The Seduction: Impasse Contributing	The Impasse	The Risk	The Alternative Intervention Style: Impasse Busting	The Techniques
The Angel	The Angel wants to please all members of the therapeutic system; interjects hope into the therapeutic system	Clients who needs hope and guidance; Conflict is high	Clients have hidden conflicts; Hesitant to talk about conflicts	The Angel stays focused on the presenting problem(s);accepts symptom as reported by members in session; does not allow conflict to develop	The Angel needs to practice making clients uncomfortable	The Archaeologist The Bird watcher The Clown The Detective The Journalist The Mediator	Accommodations Attend to nonverbal behavior Circular questioning Genogram Countersystemic tasks; Disassembling tasks Develop implicit conflicts Highlight differences Interject hope Provocative techniques Redefining the symptom Structural tasks System-restructuring Tracking
The Archaeologist	The Archaeologist wants to get to the root of the problem by examining clients' heritage in order to learn about how the past influences the present	This professional therapeutic role is positively used in almost all situations that are presented with clients	Clients who like knowing about their family history and would rather do a family search or discuss a family artifact then focusing on the presenting concerns	The Archaeologist continues to encourage clients to keep searching for family historical details when clients have limited knowledge of family	The Archaeologist needs to practice dealing with current issues at hand especially	The Angel The Bird watcher The Clown The Construction Worker The Firefighter The Savior	Accommodation Add or subtract systems Contextual tasks Countersystemic tasks; Displacing Tasks Neutral stance Redefinitions Positive reframing Provocative techniques Redefining the symptom Reinforcing patterns or tasks System-restructuring Tracking
The Bird watcher	The Bird watcher sits back, listens, and watches the members of the therapeutic system's interactional dance; says little	Clients have difficulty verbally expressing themselves but convey several non-verbal interactional behaviors; Clients try to seduce the therapist into talking for them	Clients present with highly complex and confusing interactional patterns; enmeshment	Due to the Bird watchers lack of action the interactions between clients do not change and in fact may intensify	The Bird watcher needs to learn how to take an active stance within the session	The Archaeologist The Clown The Detective The Journalist The Mediator The Referee The Teacher	Block unproductive transactional patterns Family Genogram Feedback Metaphorical tasks Provocative techniques Talking stick System restructuring

The Therapeutic Role	The Description	The Positive Use of Role	The Seduction: Impasse Contributing	The Impasse	The Risk	The Alternative Intervention Style: Impasse Busting	The Techniques
The Clown	The Clown is able to redefine the presented problems and behaviors in a (humorous) way; Clowns have a good sense of timing and balance and are able to monitor the level of tensions between people; The Clown is able to quickly improvise and make things up on the spot; The Clown is very witty and creative	The Clown introduces new perspectives in a playful but powerful way; It is a very useful role for clients, who are very rigid, have strong viewpoints or have an authoritarian member who takes themselves very seriously	Clients who present with a lot of heavy pain or families with depressed members.	The Clown's humor becomes superficial joking and discussions in relation to presented symptoms are blocked; The may Clown not be taken seriously by members and members become angry.	The Clown needs to practice listening and has to balance this role with less intrusive other professional therapeutic roles; The information gathered in the session needs to be reflected upon and used in a creative way.	The Angel The Archaeologist The Bird watcher The Journalist The Mediator The Teacher	Add or subtract systems genogram Circular questioning Contextual tasks Countersystemic tasks Displacing tasks Nonverbal techniques Family sculptures Use of metaphorical objects, drawings etc.
The Construction Worker	The Construction Worker constructs walls within the session so that pertinent information cannot be shared in or between family members.	Clients who shares vast amounts of erroneous information about the presenting symptom	Clients demand quick fix; provide little information in relation to the presenting problem	Key information regarding the presenting symptom remains limited and/ or blocked by the therapist; quick fixes fail as the symptom reappears	The Construction Worker needs to practice allowing clients to speak directly to each other or interact in a different manner	The Archaeologist The Clown The Detective The Journalist The Referee The Teacher	Accommodation Contextual tasks Family Genograms Family sculpture Mimesis tasks Tracking Use of Puppets
The Detective	The Detective is constantly searching for very small minute insignificant details; looks for a guilty party	The presenting concern of the clients is highly complex and many different viewpoints are present.	Clients present with linear thinking	The Detective dissects information into pieces; clients and therapist begin to spin their wheels; one person often blamed for presenting problem(s)	The Detective needs to practice refining interviewing techniques	The Angel The Archaeologist The Bird watcher The Clown The Journalist The Savior	Accommodation Circular questioning Constructing patterns Contextual tasks Displacing Tasks Family Genograms Relabeling and redefinition Tracking Nonverbal techniques Use of metaphorical objects

The Therapeutic Role	The Description	The Positive Use of Role	The Seduction: Impasse Contributing	The Impasse	The Risk	The Alternative Intervention Style: Impasse Busting	The Techniques
The Doctor	The Doctor speaks from medical terminology and views most problems as being individual; Interested in psycho-pharmacological and psycho - educational approaches	Clients who present clear somatic and/ or neurological concerns impacting not only the patient but also mental health of other members in therapeutic session	Clients present with somatic complaints and or have a strong tendency to label their problems as a disease of one of their members.	The Doctor hurries to heal the therapeutic members from further pain and only educates the clients about the condition and impact of the patient's (somatic) concern so clients do not grow	The Doctor needs to practice becoming more human in the session by interacting in a more personable way with clients and needs to challenge his own tendency to label problems as (brain) disease or malfunctioning.	The Angel The Archaeologist The Bird watcher The Clown The Construction Worker The Detective The Firefighter The Journalist The Savior The Teacher	Add and Subtract systems Block behaviors around symptoms Exaggerate Symptom De-emphasizing Symptom Develop Somatogram (genogram with focus on how people communicate through "organs" /somatic symptoms) Move to a new symptom Paradoxical Tasks Redefine as interactional problem Reinforce symptom Replace the symptom Structural tasks Tasks of Alliance with the symptom
The Firefighter	The Firefighter is very crisis oriented; Only a minimal amount of information gathered before engaging into action.	Clients who are very volatile and often in crisis.	Clients go from crisis to crisis. Therapist becomes overwhelmed as the crises are nonstop. Clients may become angry if the Firefighter does not react quickly to their demands	The Firefighter is quick to diagnose and offers band-aide solutions; clients become overly dependent	The Firefighter needs to practice blocking the transactional patterns of the clients and being less reactive to the presenting concerns	The Archaeologist The Clown The Construction Worker The Detective The Doctor The Journalist The Teacher	Add or subtract systems Countersystemic tasks Disassembling tasks Interviewing Approaches Family genograms Metaphorical tasks Reinforcing tasks Structural tasks System-restructuring
The Journalist	The Journalist wants to get to the root of the problem by helping clients present their life stories	This professional role is positively enacted in almost all situations that are presented with clients	Clients enter a session and are disengaged from each other and remain silent.	The Journalist continues to ask probing questions which may irritate clients resulting in a complete shutdown of information	The Journalist needs to practice patience	The Angel The Bird watcher The Clown	Accommodation Add or subtract symptoms Contextual tasks Countersystemic tasks; Displacing Tasks Focus on the Symptom Highlight differences Family sculptures Provocative techniques System-restructuring Tracking

The Therapeutic Role	The Description	The Positive Use of Role	The Seduction: Impasse Contributing	The Impasse	The Risk	The Alternative Intervention Style: Impasse Busting	The Techniques
The Judge	The Judge listens to all aspects of a situation and then renders a value opinion	Clients present situations where severe and abusive approaches are being employed by one or more of the parties present	Clients who quarrel frequently and presents scenarios of opposing opinions in regards to various situations or Clients who are in the process of a separation or divorce	A coalition is unintentionally set up between the Judge and clients thus alienating other clients in session	A Judge needs to become more "human" in the session by allowing members to interact in and among each other. He has to learn to take a much neutral stance and place "objectivity into parentheses"	The Archaeologist The Construction Worker The Detective The Journalist The Mediator The Referee The Teacher	Block transactional patterns De-emphasizing Symptom Disassembling tasks Homework tasks to practice Negotiation techniques Role-playing Tasks of attack and alliances
The Mediator	The Mediator presents a neutral stance within the session and focuses on trying to make everyone happy	Clients who quarrel with each other over rules, expectations, or life preferences for them	Clients who tend to quarrel frequently in the session over what they want and have a tendency not to see others' points of view	The Mediator makes the decision for clients so change between clients is limited; Clients become highly dependent on the Mediator	The Mediator needs to practice allowing tensions to rise in the session	The Archaeologist The Construction Worker The Detective The Journalist The Teacher The Referee	Block transactional Patterns Exaggerate the differences De-emphasize symptoms Disassembling tasks Homework to practice Negotiation techniques Role-playing
The Preacher	The Preacher has very strong philosophical ideas; The Preacher tries to impart a particular way of thinking onto the clients	Clients appear to have poor values and no role models within the family	Clients who come to therapy and have very strong ethical, beliefs and value systems to the family	Clients present double binds to the preacher as they are seeking change but are really only looking for reinforcement of their philosophical ideas	The Preacher needs to practice accommodating, listening, reinforcing and tracking their client's belief and value system without judgment	The Archaeologist The Bird watcher The Clown The Construction Worker The Journalist The Judge The Savior	Accommodation Add or subtract symptoms Block transactional patterns Exaggerate Symptom Metaphorical tasks Mimesis tasks Restructuring the system Tasks of Alliance Tracking Use humor to reframe
The Referee	The Referee is very active taking responsibility for who speaks when, for how long, and in what way.	Clients lack discipline via having no rules, and where everyone in the system does their own thing to the complete disregard of others	Enmeshed clients who have a tendency to speak for each other	Clients present to the Referee extreme double-bind situations; "Help us to monitor ourselves and at the same time do not interfere with our discussions and high levels of enmeshment"	The Referee needs to practice sitting back and observing for a few moments the highly enmeshed structural organization of the family	The Archaeologist The Bird watcher The Clown The Journalist The Mediator The Teacher	Add or subtracting systems Disassembling tasks Family genograms Metaphorical tasks Structural tasks (coalitions) System-restructuring redefinitions

The Therapeutic Role	The Description	The Positive Use of Role	The Seduction: Impasse Contributing	The Impasse	The Risk	The Alternative Intervention Style: Impasse Busting	The Techniques
The Sailor	The Sailor assumes the stance of panic and has no idea where to go next, what to say, or how to respond to lessen the tension between clients	Clients who come to therapy and a have a sense of who they are and where they want to go; require little direction; are self-motivated; minimal tension and little interaction between clients	Clients who come to therapy looking for family or couple therapy	The Sailor through silence creates confusion in and between the clients heightening their tension; presenting concern(s) never adequately addressed	The Sailor needs give themselves permission to practice new roles and techniques in a session	The Archaeologist The Construction Worker The Detective The Doctor The Firefighter The Journalist The Referee	Accommodation Add or subtracting systems Alter affect around symptom Countersystemic tasks Deemphasize symptom Develop implicit conflict Exaggerate Symptom Make a new symptom Nonverbal techniques Provide Feedback Relabeling and redefinitions Reinforcing patterns or tasks System Restructuring
The Savior	The Savior assumes the responsibility for curing all present within a session; save the scapegoat	Clients who experience abuse or may be elderly and may need more guidance than other clients; immigrants	Clients who present an identified patient (IP) or present as helpless	The Savior is very quick to act and therefore the underlying problems for the symptoms are never uncovered	The Savior needs to practice sitting back after a sense of organization has been established and letting the clients address their personal concerns	The Archaeologist The Clown The Detective The Journalist The Secretary The Teacher	Countersystemic tasks Culturogram (genogram with illustration of cultural backgrounds of the persons-illugram) Nonverbal techniques Prescribing the rules Reinforcing patterns or task Relabeling the symptom Role-playing Tracking
The Secretary	Little advice is provided and the notebook, pen and faced-down therapist is more engaged in note-taking then observing the clients' interactional nonverbal messages	Clients who are enmeshed and try to engage the therapist into their enmeshed system.	Clients who come to therapy looking for a therapist that will not openly confront them and will avoid conflict	The conflicted interactions of the clients never surface and therefore the underlying symptoms for the problem are never uncovered	The Secretary needs to practice allowing them self to be present during the session as a human being and trust that their memory will retain key information	The Angel The Archaeologist The Bird watcher The Clown The Detective The Journalist The Savior	Accommodation Countersystemic tasks Developing Implicit Conflicts Displacing tasks Family sculpture Redefinition and relabeling using Humor Restructuring tasks System-Restructuring Use of metaphorical objects

The Therapeutic Role	The Description	The Positive Use of Role	The Seduction: Impasse Contributing	The Impasse	The Risk	The Alternative Intervention Style: Impasse Busting	The Techniques
The Superman	The Superman has an unhealthy sense of responsibility, or the belief that clients lack the capacity to successfully solve their own issues and therefore they need someone to "save" them	The Superman position is not effective with any clients typology as it renders clients helpless and lowers their self-esteem	Clients who are very insecure and have low self-esteem	The Superman is so overpowering the Clients do not learn how to make decisions or develop solutions; become highly dependent	The Superman needs to practice being present during the session as a human being and trusting that they can focus on the presenting concern and together with the clients develop appropriate interventions for resolution and change	The Angel The Archaeologist The Bird watcher The Clown The Detective The Journalist The Savior	Accommodation Add or subtracting systems Contextual tasks Countersystemic Tasks Exaggerate Symptom Displacing tasks Family sculpture Genogram Move to a new symptom Nonverbal techniques like pictures, drawing Reinforcing patterns or tasks Use humor to reframe
The Teacher	The Teacher is primarily interested in educating clients; thus, every presenting issue is reduced to a lesson, and knowledge is the panacea	Clients who have had limited experience or exposure in life or to the complex concerns in which they are ensconced	Clients who present themselves as learners	The Teacher hurries into an instructional situation; minimal information is gathered so little change or growth occurs within clients	The Teacher needs to practice making clients uncomfortable	The Angel The Archaeologist The Bird watcher The Clown The Doctor The Journalist The Mediator The Referee The Savior	Accommodate Countersystemic tasks Develop implicit conflict De-emphasize Symptom Disassemble tasks Exaggerate Symptom Highlight differences Interject hope Move to a new symptom Nonverbal techniques Reinforcing tasks System restructuring Tracking

The Authors

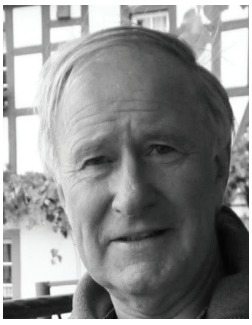
Audrey E. Ellenwood, Ph.D. Angel, Teacher, Doctor

Dr. Ellenwood has been a licensed psychologist since 1988 and has a clinical private practice. Prior to 1987 she was an elementary teacher and worked as a school psychologist. She has received family therapy training and supervision from two world re-known family therapists, Maurizio Andolfi, M.D. and Jay

Haley, Ph.D. Her specialties include family, couple, and individual therapy, psychological and neuropsychological assessments, women's support groups, and dealing with children's behavioral or emotional issues. She is the Director of the School Psychology Program at Youngstown State University. She is also *Director of Project Learning Around the World,* (www.platw.org) a 5013c charity which provides educational material and equipment for children in developing third world countries. She has served as president for various local, state, national, and international psychological associations. Dr. Ellenwood is editor of the *Ohio Psychologist* and co-chair of the Communication and Technology Committee of the Ohio Psychological Association. She has written many articles on enhancing cultural sensitivity in graduate students. As a hobby she writes children's books. Dr. Ellenwood resides in Sylvania, Ohio, USA.

Lars Brok, M.D., Doctor, Teacher, Savior

Dr. Brok is a Family Therapist, Psychodrama Therapist and Psychiatrist and, with R.Pluut, Co-Founder , trainer and supervisor in systems therapy and Director of the ISSOOH, a 26 year old family Therapy training institute in the Netherlands. Dr. Brok is a former member of the Board of the Dutch association of Family



Therapy and its Training Committee. He was editor of the Dutch Journal of System Therapy. He specialized in working with clients with psychotic experiences and their families. He also specialized in working with families and clients from different cultures and in migration related issues. From 1991 until 2007 he was head of a Multi-Functional Psychiatric Center part of Delta Psychiatric Center, in Rotterdam. He retired in 2007 but is still working about 4 months a year in centers specialized in the treatment of clients with psychotic experiences. Dr. Brok serves on the International Committee of the Academia Della Terapia Familiare in Rome, head: professor Andolfi. He has written several articles and chapters in books about family therapy and psychiatry. Dr. Brok is participating in *Project Learning Around the World (*www.platw.org*).* This project supports the education of children in underprivileged positions. He is living partly in Antwerpen, Belgium and in Le Pontreau, France. Among many other things, he is writing a cook book.

Shake-UP is a provocative read for those in the mental health field who desire self-enhancement and continued professional development. Readers will benefit through encouragement to reflect on their personal growth, their own "living culture" and to re-think their positions within a therapeutic session. Self-reflection sections will challenge the reader to think about their current professional therapeutic positions, and thereby promotes long-term professional development. Each chapter guides the reader into a higher level of understanding of his own therapeutic professional development, preferred professional therapeutic roles, and the therapeutic roles to which can be shifted into when an impasse develops.

Shake-UP is a great metaphor for an outstanding and creative book which describes the deep human nature of the therapeutic relationship with individuals, couples and families. Shaking-UP a therapist's rigidified professionals roles and cultural stereotypes in the encounter with clients or families in distress, encourages meaningful experiences and personal growth for clients and therapists.

Read this book and discover, through the Authors' voice your eighteen different professional therapeutic roles … then you will feel much freer in therapy and in your life, too!

Maurizio Andolfi, M.D.,
Director of the Accademia di Psicoterapia della Famiglia
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This book is really amazing! Two very experienced psychotherapists and family therapists, Drs. A. Ellenwood and L. Brok joined their talents to describe how the unresolved family of origin issues and the whole living culture of therapists seduce them in therapeutic contexts to adopt certain stereotype professional therapeutic roles that – if not recognized- can easily lead the therapeutic process into an impasse. But most importantly, they also gave their heart and soul to show us how to move out of these unconsciously preferred professional roles. Vividly and concretely they describe eighteen such professional roles, and with incredible creativity they show how in practice psychotherapists can switch from those rigid professional therapeutic roles into alternative intervention styles – by using the same roles in a purposefully and salutogenesis way to help the therapeutic system to get out of the treatment impasse. This book is a most inspiring read especially for family therapists but also for other mental health professionals working with individuals, couples and families.

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$45.00
ISBN 978-0-615-60893-8
54500>
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