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Transitions to systemic practice for a clinical psychology trainee

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Abstract

This article provides an individual perspective on encounters with systemic and family therapy ideas during the transition from university training to professional practice as a Clinical Psychology Registrar. Clinical psychology training provides a solid grounding in individually focussed, cognitive and behavioural models of psychotherapy. What may be less developed on entry to practice are the knowledge, procedural skills and reflective competencies needed to understand and respond to challenges in family-based therapy and in working within complex caregiving systems. Systemic ideas can provide important resources for facilitating these transitions. Trainees may need support not only in gaining knowledge of family therapy models, but also in making a challenging 'epistemological shift' (Cullin, 2014) from internalised models of psychopathology to systemic ways of thinking about problems and change. Systemic concepts and support in developing a position of 'hospitality' (Larner, 2003) towards competing therapeutic models can also help the trainee be more effective in complex caregiving environments. This article provides examples from my learning as well as reflections on what may help trainees make the transition to professional practice and make use of systemic ideas.

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"Transitions to Systemic Practice for a Clinical Psychology Intern"

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This article provides an individual perspective on encounters with systemic and family therapy ideas during the transition from university training to professional practice as a Clinical Psychology Registrar. Clinical psychology training provides a solid grounding in individually focussed, cognitive and behavioural models of psychotherapy. What may be less developed on entry to practice are the knowledge, procedural skills and reflective competencies needed to understand and respond to challenges in family-based therapy and in working within complex caregiving systems. Systemic ideas can provide important resources for facilitating these transitions. Trainees may need support not only in gaining knowledge of family therapy models, but also in making a challenging "epistemological shift" (Cullin, 2014) from internalised models of psychopathology to systemic ways of thinking about problems and change. Systemic concepts and support in developing a position of "hospitality" towards competing therapeutic models can also help the trainee be more effective in complex caregiving environments. This article provides examples from my learning as well as reflections on what helps the transition to professional practice in making use of systemic ideas.

Key Points

- Making use of systemic ideas during the transition to professional practice requires support for making an "epistemological shift" (Cullin, 2014) away from individually focussed and internalised models of psychopathology.

- Experimentation with systemic ideas can be supported through providing a safe space for reflection, modelling and eliciting appropriate professional disclosure, and exploring the interactions between the therapeutic and observing (supervisory) systems.

- Guidance in integrating concepts from cybernetics, systemic family therapy, attachment-based therapies and constructivist family therapy traditions can support the trainee to navigate complex caregiving environments and mitigate the risks and pitfalls involved in a transition to professional practice.

- The clarification of the trainee's own epistemological commitments and values for practice may support the development of a position of "hospitality" (Larner, 2003) towards alternative approaches

- In the everyday challenge of working with families, it is important to recognize the strengths and weaknesses of a range of therapeutic discourses and to employ them pragmatically within a coherent epistemological framework.

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The purpose of this paper is to explore the following questions:

- In what ways can systemic theory and practice help clinical psychology trainees make an effective transition from university training to professional practice?
- What kinds of support might help a clinical psychology trainee begin to make use of systemic ideas in their practice?

The perspective I am offering on these questions is that of someone who is in the midst of the transitions described, encountering new ideas and challenges as I exit the university system, and having recently started full-time work as a Clinical Psychology Registrar in a *Child and Adolescent Mental Health Service* (CAMHS). CAMHS services provide community-based, publicly funded, primarily short- to medium-term mental health support to children, young people and their families. In addition, we provide consultation to schools and other organisations both for specific clients and on a project basis.

Working with families and the broader systems within which they live has prompted a significant shift in my thinking about psychotherapy. After a long period of training which emphasised individually-focussed treatment models, I have found myself in situations where my existing training did not equip me with an adequate way of thinking about the challenges I faced as a therapist. Further, at times I felt ill-equipped to be an effective actor in complex caregiving systems. Systemic theories and practices from a number of traditions (including cybernetics, structural family therapy, Milan school, attachment-based and constructivist approaches) offer both frameworks for thinking and specific interventions that can meet some of these challenges.

In this article I intend to show that my key needs during this period of transition have related not just to knowledge or skill development, but also to the scaffolding of reflective

competencies which make my knowledge and skills more readily available under stress. First in Part 1, I discuss factors which have facilitated my exploration and experimentation with systemic thinking during my training. I also explore my experience of the way systemic theory represents not just a set of techniques and interventions, but involves an "epistemological shift" (Cullin, 2014) from individually-focussed accounts of psychopathology to interactional accounts of problems and change. In Part 2, I outline some of the key ideas that have been useful in therapy in making the transition from training to professional practice. These include the core Milan guidelines, the application of cybernetics to caregiving systems, constructivist approaches and attachment theory. Finally, I discuss what has helped me adjust to working in complex, multidisciplinary environments in which practitioners employ a wide range of theoretical and practical approaches to clients' distress. Here, the clarification of my own frameworks for thinking and therapeutic values supported the development of a position of hospitality (Larner, 2003) towards alternative approaches. Of course, the adjustments and transitions discussed are far from settled in my practice, and the writing of this article forms part of this process. For me, the registration and post-qualification period has been a time of transition, complexity and, at times, uncertainty and confusion. I hope that this article might provide some ideas and guidance to novice psychologists and their professional supports in making these transitions.

PART ONE: The learning environment: Feeling safe enough to experiment with new ideas

Establishing safety. In my experience as a trainee clinical psychologist, the most important factor facilitating experimentation with new ideas (including systemic and attachment theories) was having a safe and reflective environment for practice. As I sought to provide a safe haven for clients facing threats to their own emotional and physical safety, the

importance of the therapeutic environment was thrown into sharp relief. This seems particularly important in large teams and therapeutic environments, which are not immune to the dysfunctional systemic patterns that develop in families and broader systems (Boland, 2006). I note my hesitation in writing this down publicly, as if it is taboo, despite a long history of mental health professionals of all disciplines researching and writing on the dangers of controlling and/or punitive behaviours from professional caregivers (e.g. Boland, 2006; Falender & Shafranske, 2004; Main, 1957). Here I would like to highlight some of the most valuable actions from colleagues, managers and supervisors which helped me carve out a safe place for myself and for my therapeutic work.

Making space for vulnerability. Entry to practice can be a terror-inducing experience for new psychologists. I believe two responses are available to the supervisor (or colleague/manager) when they notice vulnerability or stress in the intern. First, a defensive and expert stance emphasizes the competence and invulnerability of the senior colleague while shaming the novice. When my colleagues disclosed feeling overwhelmed by the work, most were well supported but some supervisors responded with comments such as "perhaps you are not suited to this kind of work" and "you need to learn to control your own anxiety". Another colleague reported being told that "I find my students walk in with overinflated egos and my job is to knock them down by the end of placement". While these types of behaviours may be driven by supervisors' own anxieties, they can have ongoing negative impacts including persistent supervisee stress and self-doubt (Nelson & Friedlander, 2001).

I was fortunate throughout my internships to have supervisors who were able to adopt an alternative posture, acknowledging and normalizing the difficulties of therapeutic work and making space for new choices. Supervisors did this by responding sensitively as I gradually disclosed my fears and doubts about my competence. Further, they responded with empathy and a reflective stance when I disclosed what I feared were taboo responses to

clients, such as anger. Supervision of this kind also provides a model for therapy, where I hope to create a reflective therapeutic space for clients free of fear of judgement.

Disclosure and supervisory posture. Although this welcoming posture of supervisors was valuable and necessary, I would argue that for the novice a welcoming posture is not sufficient. Given that supervisee non-disclosure is a norm rather than an exception (Gunn, 2007; Ladany, Hill, Corbett, & Nutt, 1996), it may be necessary for supervisors to be more active in setting a frame in which disclosure and vulnerability is welcomed. I appreciated it when supervisors both modeled professional disclosure *and* specifically elicited my own responses to clients. By describing the tensions in their own work, supervisors normalized talking about the powerful emotional responses that inevitably arise in therapy, thereby helping me make my responses available as data for understanding the experience of clients.

Research on non-disclosure suggests the supervision relationship and the process of supervision are also important domains of silence (Gunn, 2007; Ladany et al., 1996). However, in my experience it was rare for supervisors to specifically elicit my thoughts or concerns about the supervision process or relationship. I think that making these issues more visible is valuable, both because it can address concerns in a way that leads to productive changes, and also because it models the openness and transparency that is a desirable behavior in therapists.

Reflexivity in dialogue with supervisors. Within a safe supervisory space, engaging in reflective practice with my supervisor based on recent experiences (reflection-on-action) provided good preparation for upcoming sessions. Reflective practice also provided opportunities for developing independence in clinical hypothesizing skills and in-session reflection-in-action skills (Schön, 1995; Senediak, 2013). My supervisors also made specific use of *Interpersonal Process Recall* (IPR) probes in supporting reflective practice in supervision (Kagan & Kagan, 1997). Structured reflection using IPR protocols or more

specific guidelines developed for family therapy (Senediak, 2013) are particularly helpful to me when engaging in self-supervision. Finally, watching videos of supervision with supervisors was a helpful way of facilitating discussion and led me to investigate a structured reflective practice protocol for examining supervision videos (Hill, Crowe, & Gonsalvez, 2014).

Attachment and supervision. As I applied attachment concepts to case conceptualisation and treatment planning, it became clear to me the same concepts could be applied to my own responses to clients. Just as parents experience automatic thoughts and feelings that can impair their capacity to meet children's needs (known as "Shark Music" in the *Circle of Security* protocol Powell, Cooper, Hoffman, & Marvin, 2013), my responses to clients can act as background noise that makes it more difficult to identify and meet clients' needs. Although we did not use any published guidelines for applying these concepts to supervision, they were a useful integrative framework for understanding, reflecting on and responding to my supervision needs and the needs of parents and families. Attachment research also provides a framework for understanding unhelpful compulsive, controlling or punitive caregiving, including by professionals (Cassidy & Shaver, 1999; Powell et al., 2013).

Supporting an "epistemological shift". If becoming a family therapist involves an "epistemological shift" (Cullin, 2014), then it is unlikely that the supervisee will make a single and unequivocal shift to a new way of thinking. In my experience there have been a number of competing and/or non-overlapping discourses competing for attention within my own head regarding the nature of persons, pathology, health and my role. I would argue that the clinical psychology trainee requires support not only with systemic ideas and their application, but also with the process of transition in which new ideas come into contact with and challenge old assumptions. This is an area where some of my supervisors (even those whose therapeutic practice was informed by systems theory) seemed less aware of my needs

– they seemed to take for granted key systemic assumptions that were new, obscured and/or threatening to me. This is understandable, but points to the difficulty of maintaining or recalling the perspective of a person who is still wrestling with a transition we have already made ourselves.

Where supervisors recognised and responded to this process of transition in my thinking, I was able to make more effective use of systemic ideas in my work instead of being caught up in conflicts in my thinking. For example, a number of times I went to a supervisor feeling stressed and unsure about a case and I felt a bit embarrassed when they pointed out obvious points about a family system with what felt like some frustration at my lack of insight. It was of course helpful to get the thoughts of the supervisor on the formulation, but it was even more valuable when supervisors saw that my primary problem was not lack of knowledge, but having a reduced capacity to put concepts into practice under stress in work with a specific family. Again, it was reflective practice and scaffolding for employing new ideas that was most helpful, rather than didactic teaching.

Balancing theory and practice. Another thing that was touched upon but rarely discussed explicitly with supervisors was the recursive relationship between theory and practice. While useful, the idea that practice is based on theory is an oversimplification of an often messy process of mutual influence (Flaskas, 2014). In the uncertainty of early practice I focused heavily on theoretical frameworks, testing out competing ideas for understanding clients, problems and change. Discussions of common factors research at these times was helpful in grounding my practice in the therapeutic relationship. Flaskas (2013) provides some useful guidance, suggesting that:

> "if specific practice frameworks 'activate and potentiate' common factors of change in therapy, it is the person of the therapist who activates and potentiates the capacities of practice frameworks. The change process of therapy is inextricably a process

between people (p. 287)".

Although theoretical frameworks provide essential maps for navigating therapy, at times the greater challenge for me was to manage the balance between frameworks and the relationship territory for which they provide guidance.

In this first section I have described conditions and aspects of supervision which supported my transition to professional practice, and scaffolded my experimentation with new ideas. In the next section I describe some of the specific ideas and practices that have been helpful to me in practice.

PART TWO: What I needed to learn - Helpful ways of thinking about problems and systems

In this section I describe some of the ideas and practices which I have found helpful in addressing limitations in my skills and knowledge as I exited the university system. Some of these ideas, especially those grounded in constructivist and post-structuralist traditions (e.g. White & Epston, 1990), were broadly familiar to me thanks to prior counselling training and undergraduate study in history. Others, such as practical applications of attachment and systems theories (e.g. Minuchin & Fishman, 2009; Powell et al., 2013; Tomm, 1987), were relatively new to me and are having a transformative effect on my therapeutic thinking. In addition to being clinically useful, I believe that they are helping me to gain a greater sense of ease with imperfections both in my own therapeutic behaviour and in the systems within which I work.

Clinical psychology training. My clinical psychology training at the *University of Wollongong* provided a solid grounding of knowledge and skills in cognitive and behavioural therapies. We also had clinical supervision from a range of perspectives throughout our training. Thanks to particular teachers we were given some exposure to psychodynamic and family therapy perspectives, including *Supportive-Expressive therapy* (Luborsky, 2000) and

Systemic Family Therapy (Selvini, Boscolo, Cecchin, & Prata, 1980). However, while each lecturer brought their own interests and specialties, it seems unfortunate that large domains of therapeutic thinking (including systemic ideas) were largely absent from my formal psychology and clinical psychology education.

During undergraduate and clinical training the evolution of psychology practice is often presented as a linear progression through the major paradigm shifts of the 20th Century, which obscures the theoretical diversity that is a fact of contemporary psychotherapeutic practice. The relatively narrow theoretical focus of the prescribed psychology curriculum leaves us needing particular support from supervisors, managers and/or mentors during our registration and endorsement period. For me, this meant support in my interactions with family systems, and with broader therapeutic and educational systems.

New ways of thinking about hypothesising. One of the great strengths of clinical psychology education is its emphasis on the development and testing of clinical hypotheses. The hypotheses developed within the models we were taught focussed primarily on intra-individual factors, such as avoidance of aversive experiences like anxiety. For me, a key advantage of systemic thinking has been in providing a framework for developing and testing *interactional* hypotheses. Consistent hypothesising in-session within a coherent framework is a practice I would like to develop as I seek to be a "local clinical scientist" (Stricker & Trierweiler, 1995) rather than engaging in theory-free eclecticism.

My internship supervisors have also been explicit in supporting hypothesising about the relational or attachment functions of specific behaviours. This was particularly helpful when overcoming the nominal fallacy when working with parents, whose interpretation of their children's diagnosis had contributed to an increasingly 'thin description' of the family's problems (White & Epston, 1990), which lacked narratives to support a cogent formulation or path for psychological treatment. For example, some families would come for treatment with

a diagnosis such as *Oppositional Defiant Disorder*, the nominal fallacy consisting of the propositions Q: "Why is the child being oppositional?" A: "Because he has Oppositional Defiant Disorder!" Support from supervisors in hypothesising about the attachment and other possible functions of oppositional behaviour encouraged me to do the same kind of hypothesising with families, reframing disruptive behaviours in terms of genuine and legitimate needs of children. For example, with one family ideas from attachment-focussed interventions including the *Circle of Security* (Powell et al., 2013) suggested the hypothesis that oppositional behaviour was a function of anxiety felt by both caregiver and child at moments when the parents were seeking to encourage the child's exploration.

According to the systemic family therapy tradition, hypotheses should be testable, useful and disruptive to the fixed or inflexible scripts families have about problems, especially linear hypotheses about who is "at fault" (Selvini et al., 1980). The utility of this type of reasoning became clear to me working with one young person described as "depressed and aggressive". In applying cognitive and behavioural treatment, it became clear the symptoms were primarily triggered by relational stress within the family. This prompted a broadening of focus from the presenting problems to the family system's response to a traumatic bereavement. Within this new framework we hypothesised, for example, that the young person's verbal aggression was a response to her parent's controlling and pursuing behaviours, which, though maintaining the young person's level of stress, were also an expression of love and care. Furthermore, given how often the lost parent came up during these heated family arguments, we entertained the possibility that the pattern itself was persistent because it served the function of maintaining the memory of the absent parent.

From lineal to circular assumptions. The systemic guideline of circularity (Selvini et al., 1980) further emphasises a shift from linear causality to thinking which is relational and interactional in its assumptions. Rather than asking questions to find the truth of 'things', the

Milan school invites us to ask questions which elicit new or previously unavailable information about relationships, perspectives, action sequences and their consequences and changes in relationships (Selvini et al., 1980). I have been experimenting with *triadic circular questioning* in my work and seeking to think and respond in ways outlined by the *Milan* and *post-Milan* schools (Rhodes & Wallis, 2011). However, at times I need support to sustain this way of thinking within a medically-oriented therapeutic system which emphasises diagnostic and linear thinking. Of course, lineal assumptions can usefully inform our work (e.g. providing a diagnosis where required or facilitating access to medications), but I suspect that circular or interactional assumptions will make more information available to me and my clients even when working within individually-focussed treatment models. In this period of encountering new ideas and techniques, re-introducing and reminding me of these basic systemic concepts was the main support I required.

Neutrality. The Milan guideline of neutrality suggests that the pragmatic effect of the therapist's behaviour should demonstrate alliance with all family members without siding with any particular family member or making judgements about particular behaviours (Selvini et al., 1980). This avoidance of alliances and privileged relationships with family members of family subgroups seems to be a sensible position, but one which can be difficult to maintain. I think I will have an ongoing need for support in identifying when I am drawn into coalitions with certain family members. Supervision and individual psychotherapy have both been valuable to me in understanding the kinds of situations that make it difficult to maintain a position of neutrality.

Second-order perspectives on observing systems. My supervisors and mentors have also supported me to apply ideas derived from second-order cybernetics regarding the relationship between the therapeutic and observing systems (Carr, 2012). Whereas my training predominantly posed the question, "what is happening for this individual and what treatment

should I apply?"; second-order cybernetics suggests that a more useful question is, "what is happening in this system, of which I form a part, and what does that mean I should do next?" On the one hand systemic perspectives can be overwhelming because they broaden the frame to include all relevant actors in the system and all the complexities that entails. On the other hand, they offer a freedom in recognizing that my role in the system, while important, is limited and has effects that can only be imperfectly predicted (Carr, 2012; Tomm, 1987).

Supervision conversations which involved reflection on the observing system was a key support for me in making an epistemological shift from linear to interactional theories of change. It was particularly powerful when my supervisors helped me identify how my responses to clients resulted in "isomorphic replication or recursive patterns" (Bateson, Jackson, Haley, & Weakland, 1956) – where patterns in therapy appeared to be replicated in supervision (also known as parallel process). Further, it was helpful when a supervisor either acknowledged or met an attachment need that had arisen in supervision, especially moments where I needed help to contain or understand strong emotions, which seemed to be more common for me when discussing clients that present with significant emotional dysregulation. For example, on one occasion when working with one client with a long history of panic, agoraphobia and reliance on others, I presented in supervision as helpless and hopeless about therapeutic progress. Watching a video of this supervision session, my supervisor and I were able to notice this helplessness, sensing invitations to a rescuing role for both me and the supervisor. This reflective space allowed me to return to therapy with a renewed focus on helping the client take a central role in promoting change in her life.

In another example, working in co-therapy with a young person showing emotional dysregulation and suicidal ideation, my colleague and I sought the consultation of our team leader and our consultant psychiatrist. The young person's parents wanted to help but often responded to suicidal and parasuicidal behaviours in ways that the young person experienced

as invalidating and punitive. The key task in the session was to help the family take charge of their safety and, if appropriate, avoid a hospital admission. Rather than step in and take over the session, our senior colleagues listened carefully to our concerns and anxieties and communicated their confidence that we could handle the situation without their direct input. We returned to the session with the confidence to contain the distress and anger of both the parents and the young person. The family, in turn, found the confidence to take charge of safety and the parents subsequently engaged in family sessions for the first time. I was struck by the implicit meaning of our senior colleagues not taking over from us – I wonder if it helped us communicate confidence to the family that they didn't need us to take over from them. In other situations having senior colleagues enter the system in the middle of a crisis has appeared to escalate power struggles rather than defuse them, resulting in increasing anxiety for both clients and therapists.

Perfectionism and enactment. During my training and in early practice I often felt a strong need to be the perfect therapist and provide a perfect experience of therapy for clients. I worried terribly when I, or the therapeutic environment, did not meet what I judged to be my client's needs. Initially I found systemic perspectives to be overwhelming, perhaps because my reflex was to infer that my responsibility for the therapeutic environment was even greater than I had previously assumed. Minuchin's concept of enactment was helpful in this context (Minuchin & Fishman, 2009). As I saw that it was normal and even useful for problematic relationship patterns to be acted out and worked through in the consulting room, I was increasingly able to resist the temptation to step in to 'protect' the client in unnecessary or unhelpful ways.

Whereas before I would feel a responsibility to change systems or to want other systemic actors to see things the way I saw them, increasingly I am feeling comfortable to let enactment happen, notice it and process it with clients during or after the fact, rather than

attempting to prevent or arrest it. For example, as an inexperienced worker, a number of times while providing systemic consultation I have found myself providing direct advice to educational professionals in ways that elicited resistance. I found myself providing well-intentioned suggestions which did not take into account the context and needs of the system and/or family, and my interlocutor would end up providing a list of reasons why my idea would not work. A shift to systemic thinking hasn't stopped me from slipping into unhelpful behaviours at times, but it has provided me with a way of thinking that helps me work out when I am doing it. I think that the support I need in these situations relates to reflecting on my own anxieties about systemic consultation, including a perceived need (and sometimes pressure within systems) to have 'all the answers' and take on the expert role. The most useful question seems to be "what was it like to be in the meeting?" This orients me to whether I felt aligned or under pressure to take the expert role or force a particular outcome.

Attachment and case conceptualisation. Attachment theory has had a growing influence on my practice since graduation. Working with families, attachment concepts provide a useful framework for understanding the functions of behaviours in terms of children's legitimate needs rather than focussing solely on "positive" and "negative" behaviours. Attachment theory provides grounding for techniques and interventions in their own right (e.g. Circle of Security, Powell et al., 2013). Also, and equally importantly, attachment theory can provide a framework for optimising cognitive and behavioural formulations or treatments (e.g. Scott & Dadds, 2009). I have also found that COS provides a simple visual metaphor for judging whether a client or other systemic actor is requiring a supportive/validating (bottom of the circle) response, or expressive/change-oriented (top of the circle) response from me. I needed support in developing sensitivity to subtle cues from clients which signaled their attachment needs. Reviewing videos of therapy with my supervisor was a helpful way of reviewing these

cues in the moment-to-moment interactions of therapy. It also helped to identify, normalise and moderate my pendulum swings in response to new ideas.

Part Three: Navigating complex caregiving environments by developing a position of "hospitality"

In this section I describe ideas and processes which I have found helpful working in systems, including systems where my own therapeutic values and theoretical preferences are not dominant. I explore how attachment concepts and developing a position of "hospitality" (Larner, 2003) towards the caregiving behaviours of others has helped me to navigate complex caregiving environments.

Personal commitments. One of the biggest challenges for me in entering professional practice was how to respond to what I perceive(d) to be the negative impacts of therapeutic discourses and practices that:

- Located pathology solely within the individual
- Demanded compliance rather than invited collaboration
- Imposed normative frameworks rather than seeking to understand the experience of the individual
- Focussed on problems without attention to context or strengths

While I still believe that these kinds of therapeutic postures are usually unhelpful, it seems clear that the temptations of the expert role and pathologising practices are present for all of us, and simply protesting their existence is unlikely to serve me or my clients. Rather, I need a framework for advocating effectively for what I believe to be more useful alternatives. I can also now see that at different points in my learning I, too, have developed inflexible positions in support of particular (usually constructivist) therapeutic discourses. This both blinded me to the value of other traditions and made it more challenging to work with colleagues holding different views. Two supervisors supported my development in this area by consistently and

empathically validating the frustrations I felt towards specific therapeutic practices and postures, while gently encouraging me to hold a position of "hospitality" towards other ideas. As Larner (2003) puts it, "before family therapists can expect a more discursive and relational response from other mental health practitioners, they must demonstrate it themselves" (p. 212).

Given these pre-existing commitments, I required support during my training to navigate a number of practices and ideas within clinical psychology, nursing and psychiatry. I needed support to hypothesise about the underpinnings of alternative positions, and to understand the strengths and limitations of these discourses. I found that when I could develop hypotheses about *why* a family member or professional caregiver might take a particular position with respect to a client's problems, then I was more able to sit with the discomfort of what I perceived to be unhelpful interpersonal processes in therapy or meetings. For example, when caregivers became involved in confrontation-denial traps with clients (Miller & Rollnick, 2002), I was supported by supervisors to hypothesise about the motivations, anxieties or needs that might be driving the unhelpful caregiving behaviours.

Further, working on a number of psychiatric wards I have been witness to and implicated in the dangers outlined by Main (1957), who argued that persistent exposure to the distress of patients can evoke primitive responses from therapists, whereby the therapist alleviates his or her own distress (or "Ailment") through the application of increasingly restrictive, controlling or desperate therapeutic interventions. The key focus of Main's research was on the prescription of sedatives, however he also argues that:

> "there can never be certain guarantee that the therapist facing great and resistant
> distress will be immune from using interpretations to soothe themselves when
> desperate, and to escape from their own distressing ailment of ambivalence and hatred.

The temptation to conceal from ourselves and our patients increasing hatred behind

frantic goodness is the greater the more worried we become (p. 130)".

Early on my tendency was to feel drawn to rescue or align with my clients against those

practices and structures which I viewed as anti-therapeutic. These included totalising

discourses (White & Epston, 1990) in which the behaviour of patients was understood

primarily within a diagnostic framework, leading to the pathologizing of normal behaviours

or client reactions to coercive or controlling caregiving responses such as seclusion and

restraint. In the early months I felt helpless and did not have a clear framework for thinking

about what kind of action might be useful from me. For example, on one occasion I found

myself triangulated between a colleague and a client who had a long history of relying on

others when managing her pervasive difficulties with panic and interpersonal relationships. I

now understand that it is normal for staff members to be drawn into strongly-held opposing

views about treatment for clients with these sorts of presenting problems (Main, 1957), likely

based on their own attachment-based sensitivities (Powell et al., 2013). At the time, however,

I felt angry and caught between a need to maintain my relationship with a senior colleague

and a desire to protect the client from what I perceived to be unhelpful and controlling

behaviour on the part of my colleague. My supervisor suggested that my role in such

situations might be to orient the client to situations which are not ideal rather than protect the

client from those situations. It would also have been helpful to have support in hypothesising

about what attachment sensitivities might push a well-intentioned caregiver to act in the ways

that I was describing.

It also strikes me that knowing something about the *Theory of Logical Types* would

have been helpful here (Cullin, 2014; Whitehead & Russell, 1927). What matters is not just

the meaning of our verbal communication ("report" function), but the implicit

communication implied by our words and actions ("command" function) (Bateson et al.,

1956). For example, I may perceive controlling caregiving by a family member or other systemic actor, which I perceive to be undermining the autonomy of my primary client. But if I step in and directly interrupt that process I will inadvertently undermine the autonomy of my client because my intervention presumes that they cannot protect themselves. Here the meaning of my communication (attempting to stop coercive behaviour in order to protect the autonomy of the client) contradicts the meaning conveyed at a second (or implicit) level ("I don't trust you to manage this situation on your own").

Since my experiences in inpatient contexts, I have made a number of shifts in my practice when working in an interdisciplinary context with colleagues whose training or practice emphasises different epistemological commitments to my own. First, I seek to carefully delineate the responsibilities that each of us will take with respect to the therapeutic work. Where I am the primary clinician, this often involves stepping more confidently into my role and welcoming my colleague into the therapeutic relationship that has already developed. I have found that it is helpful to frame any differences of opinion regarding treatment explicitly in terms of differences in formulation, resisting the temptation to engage in value conflicts with colleagues or other caregivers. This helps maintain a perspective that looks for the positive intentions that caregivers almost always have for clients. I have also learnt to be very clear and open in my communication with colleagues when working with clients who, by virtue of their own emotional dysregulation and sensitivities in close relationships, invite alignment and give inconsistent histories to different caregivers.

These shifts required a level of confidence in my skills and therapeutic values that were difficult to establish as a trainee. Therefore, while I appreciated the level of autonomy afforded me by my supervisors during my internships, I would argue that an important role for the supervisor is to provide explicit modelling and guidance to the supervisee in the early

days of navigating complex caregiving environments such as hospitals and large mental health services.

Clarifying my own position. Identifying and taking responsibility for the assumptions in my own therapeutic practice was a first step towards *hospitality* towards the positions of others (Larner, 2003). In practical terms, clarifying my position involved my evolving response to the following questions:

- What is a person?

- What is health and what is pathology?

- What is treatment and what is the role of the therapist?

- What relationship do I want to develop with professional power, including my own?

- What type of research evidence should underpin practice?

I feel that answers to these questions can provide the foundation for an integrative framework within which technical eclecticism is justified. The questions have a number of sources but the biggest influences for me and my supervisors were the formulation model of Carr (2006) and Tomm's writing on epistemology and the shift from strategizing to reflexivity in *Interventive Interviewing* (Tomm, 1987). Acknowledging my positioning to myself, my supervisor and, when appropriate, to my clients, has helped me shift to a more straightforward and frank posture as a psychotherapist.

Conclusion: Where to from here?

As I look to my present situation and my hopes for the future, it strikes me that the process of researching and writing this paper has been part of my own "epistemological shift" to a systemic "way of thinking" (Cullin, 2014). I am surprised by the extent of the shifts that I have needed to make over the past two years, despite a long-standing openness to systemic and constructivist thinking. It must have been frustrating at times for my supervisors to see me lost in the fog, and I appreciated when they were able to strike the delicate balance of

supporting my autonomy while providing just enough validation and resources for me to find my way.

I am hoping to shift from a posture of seeking a single therapeutic discourse that suits me, to being able to recognise the strengths and weaknesses of a range of therapeutic discourses and to employ them pragmatically within a coherent epistemological framework. Carr's (2012) formulation model, Tomm's (1987) writings on Interventive Interviewing and Flaskas' (2014) perspectives on balancing tensions within the teaching and learning process seem to provide good support for developing supervisees' own frameworks for practice in this area. What remains for me to do is to convert a declarative knowledge of these frameworks to a fuller set of procedural skills which will make this knowledge available under the stress of everyday work with families.

Furthermore, the question of whether to identify explicitly as a "family therapist" remains open. Do I follow the path of specialist training in family therapy or do I just keep reading and aim for my practice to be "informed" by systemic ideas? For now I think I am moving between monadic and systemic ways of thinking with less awareness than I would like. This may be a function of the cognitive dissonance involved in trying to reconcile conflicting and non-overlapping discourses about problems, therapy and change. I feel I will need ongoing guidance on how to employ these different postures in a more conscious and strategic way. Over time, I hope that systemic perspectives on observing systems will also provide me with a coherent way of reflecting on my interactions with families and broader systems, helping to maintain critical control over practice and keeping my part in systems as helpful as possible.

References

Bateson, G., Jackson, D. D., Haley, J., & Weakland, J. (1956). Toward a theory of
schizophrenia. *Behavioral science, 1*(4), 251-264.

Boland, C. (2006). Functional Families: Functional Teams. *Australian and New Zealand Journal of Family Therapy, 27*(1), 22-28. doi: 10.1002/j.1467-8438.2006.tb00688.x

Carr, A. (2012). *Family therapy: Concepts, process and practice*: John Wiley & Sons.

Cassidy, J., & Shaver, P. R. (1999). *Handbook of attachment: Theory, research, and clinical applications*: Rough Guides.

Cullin, J. (2014). On learning and teaching family therapy. *Australian and New Zealand Journal of Family Therapy, 34*, 352-369. doi: 10.1002/anzf.1037

Falender, C. A., & Shafranske, E. P. (2004). *Clinical supervision: A competency-based approach*. Washington, DC: American Psychological Association.

Flaskas, C. (2013). Teaching and learning theory for family therapy practice: On the art and craft of balancing. *Australian and New Zealand Journal of Family Therapy, 34*, 283-293.

Gunn, J. E. (2007). *Supervisee attachment: Relationship to the alliance and disclosure in supervision (Doctoral disseration).* Available from ProQuest Dissertations and Theses database. (ID No. 304839374).

Hill, H. R. M., Crowe, T. C., & Gonsalvez, C. J. (2014). Reflective dialogue in clinical supervision: A pilot study involving collaborative review of supervision videos. *Psychotherapy Research, In Press*.

Kagan, H., & Kagan, N. (1997). Interpersonal Process Recall: Influencing human interaction. In C. E. Watkins, Jr. (Ed.), *Handbook of Psychotherapy Supervision* (pp. 421-446). New York: Wiley.

Ladany, N., Hill, C. E., Corbett, M. M., & Nutt, E. A. (1996). Nature, extent, and importance of what psychotherapy trainees do not disclose to their supervisors. *Journal of Counseling Psychology, 43*(1), 10-24. doi: 10.1037/0022-0167.43.1.10

Larner, G. (2003). Family Therapy in Child and Adolescent Mental Health Practice:
   Integrating Family Therapy in Child and Adolescent Mental Health Practice: An Ethic
   of Hospitality. *Australian and New Zealand Journal of Family Therapy, 24*(4), 211-
   219.

Luborsky, L. (2000). *Principles of psychoanalytic psychotherapy: A manual for supportive-
   expressive treatment*: Basic Books.

Main, T. F. (1957). The Ailment. *British Journal of Medical Psychology, 30*, 129-145.

Miller, W. R., & Rollnick, S. (2002). *Motivational Interviewing: preparing people for change*
   (2 ed.). New York: Guildford Press.

Minuchin, S., & Fishman, H. C. (2009). *Family therapy techniques*: Harvard University
   Press.

Nelson, M. L., & Friedlander, M. L. (2001). A close look at conflictual supervisory
   relationships: The trainee's perspective. *Journal of Counseling Psychology, 48*(4),
   384-395. doi: 10.1037/0022-0167.48.4.384

Powell, B., Cooper, G., Hoffman, K., & Marvin, B. (2013). *The Circle of Security
   Intervention: Enhancing Attachment in Early Parent-child Relationships*: Guilford
   Publications.

Rhodes, P., & Wallis, A. (Eds.). (2011). *A practical guide to family therapy: Structured
   guidelines and key skills*. East Hawthorn: IP Communications.

Schön, D. A. (1995). *The reflective practitioner: How professionals think in action*.
   Aldershot: Arena.

Scott, S., & Dadds, M. R. (2009). Practitioner Review: When parent training
   doesnelationshipship-driven clinical strategies. *Journal of Child Psychology and
   Psychiatry, 50*(12), 1441-1450.

Selvini, M. P., Boscolo, L., Cecchin, G., & Prata, G. (1980). Hypothesizing—circularity—

neutrality: Three guidelines for the conductor of the session. *Family Process, 19*(1),

3-12.

Senediak, C. (2013). Integrating Reflective Practice in Family Therapy Supervision.

Australian & New Zealand Journal of Family Therapy, 34(4), 338-351. doi:

10.1002/anzf.1035

Stricker, G., & Trierweiler, S. J. (1995). The local clinical scientist: A bridge between science

and practice. *American Psychologist, 50*(12), 995.

Tomm, K. (1987). Interventive interviewing: Part I. Strategizing as a fourth guideline for the

therapist. *Family Process, 26*(1), 3-13.

White, M., & Epston, D. (1990). *Narrative means to therapeutic ends*: WW Norton &

Company.

Whitehead, A. N., & Russell, B. (1927). *Principia mathematica* (Vol. 1): Cambridge

University Press Cambridge.