



The Challenge of Creating Dialogical Space for Both Partners in Couple Therapy

Peter Rober

Context, Leuven, Belgium

Dialogue in marital and family therapy (MFT) is by definition a multi-actor dialogue. This raises important challenges for therapists since the conversation is often tension filled and can have dramatic real life consequences for family members. In this paper I focus on the challenges presented in working with couples. In the first part of the paper I develop a theoretical frame, which relies on the MFT literature on the therapeutic relationship as well as on the discussion in the field around the therapeutic relationship and the concept of not knowing. I question the therapeutic effectiveness of the therapist's egalitarian intentions and the idealistic view of the naturally healing dialogue implicit in not knowing. I especially highlight the validity of some of the concepts of Mikhail Bakhtin (e.g., addressivity, responsibility) to address the specific complexities of the MFT encounter. Then I present a case study, which is limited to a microanalysis of the first minutes of a first session of a marital therapy. In the third part of the paper I discuss what I have learned from the case study against the background of some of the central ideas developed in the first part. This leads to the conclusion that the marital and family therapist cannot escape the uncomfortable position of being responsible to find ways to actively contribute to a helpful dialogue with clients; a dialogue that is not a natural given, but rather a project that needs the therapist's constant consideration and care.

Keywords: marital therapy, therapeutic relationship, dialogue, otherness, responsibility, agonism, dialogical space

Key Points

- 1 The therapeutic relationship in a multi-actor setting is complex.
- 2 Free and spontaneous dialogue, in which mutual understanding and intimacy can grow, is the exception rather than the rule as tension is at the core of dialogue.
- 3 As a therapist who adopts a receptive stance too early in the first marital therapy session can reinforce an already existing imbalance in the couple, the therapist cannot escape the uncomfortable position of having the responsibility to find ways to actively contribute to a helpful dialogue with the clients.
- 4 A couple therapist needs to find a way to transform the antagonism in the relationship into an agonism, in which tension and conflict are accepted and talked about, and in which the partner can sometimes be seen as an opponent or an adversary, but never as an enemy.

There is considerable scientific evidence that marital and family therapy (MFT) works for a wide range of problems (Carr, 2009a, 2009b) and, as in other kinds of therapy, probably the most potent factors in MFT are so called *common factors* (Sprenkle, Davis & Lebow, 2009). These are therapeutic factors that MFT shares with other kinds of therapy. However, besides these common factors there is also the specificity of MFT (Sprenkle & Blow, 2004) that has to do more with the characteristics of the MFT setting, than with the underlying theoretical model. Dialogue in MFT is by definition a multi-actor dialogue (Seikkula, Laitila & Rober, 2012), in marital therapy it is a dialogue of the therapist with two partners of the same

Address for correspondence: peter.rober@med.kuleuven.be

generation, and in family therapy it is a dialogue with at least two family members of at least two different generations.

The fact that sessions of marital and family therapists are essentially multi-actor dialogues raises important challenges for therapists. For instance, while the therapeutic relationship is one of the most potent factors in all therapies, the therapeutic relationship in MFT is more complex than in individual therapy as the family members bring their differences and their conflicts into the consultation room. Furthermore, the MFT session is not just a transitional space (Winnicott, 1958) in which people can free-associate. Often the tension is high in MFT sessions as the other family members hear everything that is said. Furthermore, real-life consequences often are the result of decisions made in MFT sessions, such as the decision to file for divorce, the decision to place a child in residential care, or the decision to report family violence. Within such a high-tension context, it is not easy for the therapist to form an effective therapeutic alliance with each of the family members, as well as with the family as a whole.

In this paper I reflect on the complexity of the therapeutic relationship in a multi-actor dialogue, and I focus especially on the way a therapist can deal with the tensions and differences that are so often present in such a context. In the first part of the paper I develop a conceptual frame in which I rely on the MFT literature on the subject as well as on the conceptual discussion in the field around the concept of *not knowing*. Furthermore, I especially highlight the validity of some of the concepts of Mikhail Bakhtin (1981, 1984, 1986) to address the specific complexities of the MFT encounter. Then I present a case study in which I limit myself to microanalysis of the first minutes of a first session of a marital therapy. In the third part of the paper I discuss what I have learned from the case study against the background of some of the central concepts and ideas I have previously discussed.

Conceptual Frame

The therapeutic relationship in MFT

In the MFT field there has been fierce debate about the characteristics of an effective therapeutic relationship. In the 1970s and 1980s, when the cybernetic perspective still reigned in the field, the debate focused on the epistemology of strategy and control, and the importance of the therapist as a directive interventionist (Hoffman, 1981). Although there was extensive discussion about the therapeutic relationship, often the family therapist was seen as an outsider to the family who could intervene on the family structure in order to optimise family functioning. Since the narrative turn in MFT, the focus has been more on the ethical aspects of the therapeutic relationship. The influence of social constructionism (Gergen, 1999) on the MFT field has been vast, and the suspicion towards the notion of objective knowledge has highlighted the importance of ethical values in the therapist's decision making.

In the conceptual and philosophical struggles of theorists and therapists with the ethical aspects of the therapeutic relationship in MFT practice, gradually the concept of *not knowing* became very important. The concept was originally described as a general attitude in which the therapist's actions communicate a genuine curiosity (Anderson & Goolishian, 1992). In order to really listen to the client's story, and to really understand what the client means, the therapist needs to be *not knowing* in the sense

that he/she has to suspend his/her own assumptions and preconceptions, and be open to what the client wants to convey (Anderson, 1997). The therapist is not the expert, but rather the client is seen as such (Anderson & Goolishian, 1992).

The notion of the client as an expert does not deny that a therapist has expertise. The concept does not dispute that therapists have knowledge – theoretical and experiential, professional and personal: ‘A therapist cannot be a blank screen, void of ideas, opinions, and prejudices . . . On the contrary, we each take who we are, and all that entails – personal and professional experiences, values, biases, and convictions – with us in the therapy room’ (Anderson, 1997, p. 137). Clearly, according to Anderson, the therapist’s mind is not empty. He/she has opinions, ideas, and feelings, just as the client does. However, in contrast to the client, who is expert of his/her own life, the therapist’s expertise is in the area of process, instead of the area of the content of the conversation: ‘. . . [A] therapist is the expert in engaging and participating with a client in a dialogical process of first-person storytelling’ (Anderson, 1997, p. 95). Explaining what she means by this, Anderson highlights the importance of the receptive aspect of the therapist’s expertise: to ‘invite, respect, hear and be engaged in a client’s story’ (Anderson, 1997, p. 95).

While *not knowing* became a landmark concept in the MFT world, there also has been a lot of controversy over the concept. It should be noted that, in fact, the criticism was often not directed towards the concept itself, but rather towards its literal interpretation or towards its uncritical and one-sided application to the complexity of MFT practice (Rober, 2005a). For one thing, some authors have argued that the concept insufficiently addresses therapy as a dialogical phenomenon. David Paré (2002) for instance, maintains that by unilaterally stressing the expertise of the clients, the concept of *not knowing* betrays an underlying individualistic perspective on the therapeutic relationship. As Paré remarks, ‘[t]he notion of client as expert . . . failed to capture the tenor of an intersubjective relationship. It does not dismantle the notion of individualistic expertise: it merely shifts it from the therapist to the client’ (p. 32). According to Paré, the *not knowing* concept does not capture the mutuality and shared activity of a therapeutic relationship, as the therapist’s lived experience in the encounter with the family is not valued.

Another interesting objection to the uncritical use of the concept of *not knowing* has to do with its denial of power issues in relationships. Guilfoyle (2003) explores the relationship between dialogue and power in the practice of *not knowing* forms of therapy. According to Guilfoyle, therapists relying on the *not knowing* concept associate power with authority, domination and control, and implicitly propose that the removal of power from therapy is an ethical imperative for dialogical therapies. These therapists also seem to assume that removing power from the therapeutic relationship, in and of itself, would lead to therapeutic change. In that way power is considered an obstruction to dialogue as it limits the dialogical space for the client. However, introducing Foucault’s concept of power, Guilfoyle argues that power relations can infuse dialogue, without compromising the dialogical status of the interaction: power and resistance work together to produce a dialogical encounter (Guilfoyle, 2003).

Acknowledging the risks of relying one-sidedly on the expertise of the client, as well as the importance of the therapist’s reflections and his/her relational knowledge, some authors have stressed the necessity of framing the concept in a broader dialogical perspective (e.g., Anderson, 2012; Rober, 2005a). Nowadays, hardly any family therapist denies the importance of *not knowing* for MFT practice. The immense influence

of the concept in the MFT field is emblematic of the way family therapists have tried to deal with the ethical challenge of being in a therapeutic relationship with clients. The concept of *not knowing* is just one example of the different ways in which family therapists have emphasised the importance of otherness in the therapeutic relationship. These family therapists have often found their inspiration in the work of philosophers like Derrida (Larner, 1999; Rober & De Haene, 2013), Levinas (Larner, 2004), and Foucault (White & Epston, 1990). More recently, Mikhail Bakhtin also has been an inspiration for some family therapists who have conceptualised MFT as a dialogue (Rober, 2002a, 2002b, 2005b; Seikkula & Olson, 2003; Seltzer & Seltzer, 2000). Referring to some of these sources of inspiration, we will reflect in this paper on the complexity of creating dialogical space in MFT practice.

Dialogue

While Bakhtin's dialogical concepts have found a place in contemporary family therapeutic reflection, in the MFT literature the concept of dialogue is often used in an idealising way. Usually it is rather simplistically framed in opposition to monologue, implicitly suggesting that good therapy is dialogical, while bad therapy is monological; or arguing that clients enter therapy with fixed, monologic stories, and that therapy consists of dialogising these stories (Penn & Frankfurt, 1994). Some authors have used dialogical concepts mainly as a way to legitimate the rejection of the therapist's expert position and describe the therapist's task as listening empathically to the client's story from a *not knowing* position (Anderson, 1997).

However, the concept of dialogue in Bakhtin's work is complex (Vice, 1997) and it cannot be described simply as the opposite of monologue. Indeed, in a sense monologue can be understood as a part of dialogism, and we can speak of dialogical dialogues and monological dialogues (Morson & Emerson, 1990). In every conversation there is a dynamic tension between the monological and the dialogical dimensions of a conversation (Shotter, 1993). This illustrates something of the complexity of Bakhtin's concept of dialogue, of which Bakhtin scholar Caryl Emerson (1997) writes: 'Dialogue is by no means a safe or secure relation. Yes, a "thou" is always potentially there, but it is exceptionally fragile; the "I" must create it (and be created by it) in a simultaneously mutual gesture, over and over again, and it comes with no special authority or promise of constancy . . . Imbalance is the norm' (pp. 229–230).

According to Bakhtin, life is an ongoing, unfinalisable dialogue continually taking place (Morson & Emerson, 1990). There is a constant tension in dialogues between what is said and what is not said, as language is the product of dynamic, tension filled processes in which two tendencies are involved: the centripetal (centralising, unifying) forces and centrifugal (decentralising, differentiating) forces (Bakhtin, 1981; Baxter, 2004; Baxter & Montgomery, 1996). While Hegelian dialectics prescribe the finalisation of dialectic tensions in a synthesis, in Bakhtin's view these dialogical processes never find rest. In his words, they are *unfinalisable*, which means that dialogue is not a tranquil state of equilibrium. Rather, the tension between the two opposing tendencies is perpetual and never finds a final solution. As Baxter (2004) writes, 'This view stands in sharp contrast to dominant approaches to relational communication . . . [that] . . . have articulated the grand narratives of connection, certainty and openness' (p. 114). In these approaches autonomy is linked with distance and secrecy between partners. Intimacy is linked with openness, and closedness is viewed as problematic and unhealthy.

From a dialectical perspective, however, these approaches underestimate the importance of the continuous dynamic interplay of centripetal and centrifugal forces, as well as the uniqueness of every moment and the shaping force of the time and place of the dialogical exchange. In other words, there is a constant tension between expression and non-expression in relationships, and what is actually said or not said in relationships is not the final outcome of a process, but rather is a momentary freeze frame of the tension, uniquely shaped by the dialogical context.

Otherness and dialogical space

One of the most interesting contributions of Bakhtin's thinking to the field of MFT is that his concepts allow family therapists to reflect on some of the complexities of the family therapeutic encounter. These include multiplicity (e.g., dealing with the different stories about the same events), the therapist's self (e.g., the therapist's becoming part of the family while remaining an outsider), and power (e.g., the therapist leading the session by making dialogical space for the clients).

Being a scholar of literary theory and studying novels of Dostoyevsky Rabelais and others, Bakhtin often thought in terms of *Authors* and *Heroes*. In Bakhtin's psychology, authoring is a central concept (Morson & Emerson, 1990): I (the Author) take shape in dialogue with the other (the Hero). I can only start to get to know myself through the other's outsideness. Through the continual dialogical process with others, my self – distinct from those others – is in a constant state of becoming; I am different from others and it is exactly by this constant and ever-changing dialogue with otherness that I continuously become the distinct centre of experience that I am (Salgado, 2007; Salgado & Gonçalves, 2007).

The other is central in Bakhtin's thinking, not only in his thinking about the self, but also in his theory of the speech act. Dialogue is not possible without the other (Marková, 2003). According to Bakhtin (1986) my speech is never my speech as it is addressed to the other (addressivity), and a response from the other is anticipated (Bakhtin, 1986). What I say is always a response to what has been said before, and in addressing the other, my utterance is not only shaped by the anticipated response of the other, it also invites a response from the other (responsivity) (Bakhtin, 1986).

Positioning

While addressivity and responsivity refer to the fundamental dialogical nature of our being, these concepts also touch upon challenges for the therapist since, according to Bakhtin, no speech is value free (Morson & Emerson, 1990). As a therapist, I cannot be *positionless*, because in each utterance I take up a position revealing my evaluation of what has been said before. Taking a position, I invite the other also to take a position by proposing his/her position and waiting for his/her response, which implicitly or explicitly accepts or challenges the position I have proposed.

Positioning theory (Davies & Harré, 1990; Harré & Van Langenhove, 1999) is an important enrichment of reflection on the therapeutic session in the field of MFT as it opens space to talk about the rhetorical aspect of the encounter (Billig, 1996). Positioning implies a spatial metaphor linking a voice with a point of view from which one observes reality. Each point of view gives one a perspective, but at the same time it has inherent limitations: from each point of view some things can be

seen, while others remain out of focus, in the shadows or out of sight. Dialogue consists of the meeting of different points of view, in which each voice expresses something from its perspective, activating another voice speaking from another point of view. These other voices are evoked in a continuous game of agreement/disagreement, on the content level (Watzlawick, Beavin-Bavelas & Jackson, 1967): each new voice agrees or disagrees with the previous one. On the relational level (Watzlawick et al., 1967) agreement/disagreement is not central, but what Linell (2009) calls sharedness/difference: each new voice takes a position of 'I'm like you' (sharedness) or 'I'm not like you' (difference) in reference to the previous voice. This evoking of one voice by another can be observed in dialogues between interlocutors, but it can also be observed in inner dialogues in which each inner voice evokes other inner voices in dialectical tensions with each other (e.g., Rober, 2005a, 2008).

Since a distinction can be made between story (content) and storytelling (process) in dialogue, we can also distinguish between representational positioning and interactional positioning (Wortham, 2001). *Representational positioning* refers to the positions of the characters in the story (content), while *interactional positioning* refers to the positioning of the speaker, the addressee and the audience in the storytelling situation (process). In MFT, more than in individual therapies, interactional positioning – how the family members position themselves in the here-and-now of the session – needs careful consideration. As family members contrast their perspectives to the positions that they attribute to the others, conflict and disagreement are interesting phenomena to observe in family session. They refer to the continuous dance of changing positions in the session, giving the therapist some sense of what is at stake for the family members.

However, the therapist is also part of the dialogue. This means that he/she is also invited to take positions in the family's performance (Rober, 2005a; Rober & Seltzer, 2010). The task for the family therapist is to remain sensitive to the family's invitations and to guard his/her mental space to reflect on this positioning (Rober, 2011). Do these invitations open space for stories untold? Do they add to the security in the session? Do they leave enough space for other family members to move flexibly in the family performance?

Dialogue in marital and family therapy

The concept of positioning can help us to address the specific challenges for the marital and family therapist, as it sets the stage for addressing tension, coercion, conflict and violence, as inherent potentialities of dialogue. Often in dialogue others are forced to speak, to listen, or to act. Or they may be silenced by intimidation, or threatened to abstain from acting. Free and spontaneous dialogue is the exception rather than the rule in our world (Fogel, 1985, 1989).

Free and spontaneous dialogue, in which mutual understanding and intimacy can grow, is what most therapists aim towards. The challenge for a couple or family therapist is how to position oneself in the session, in such a way that (i) the chances of a constructive conversation are increased through dialogue and (ii) the risk of violence, repression and coercion are lifted as much as possible from the dialogue. Or, in other words, how can dialogical space be created in the therapy session, in such a way that there is room for growth and understanding? This is a challenge, because family therapeutic conversations so often are explicitly or implicitly filled with tension and rich in conflicts that have long and painful histories.

In the following section I address this challenge of creating dialogical space in a therapeutic encounter, and I focus on a marital therapy encounter. However, before I shift to therapy practice, a remark should be made. In talking about therapeutic practice, I take the perspective of the therapist – what Bakhtin (1993) would call the *I-for-myself* and the *other-for-me* positions – and address some of the issues that are raised for the therapist in dealing with otherness. For some readers this might come as a surprise, because it seems antithetical to the dialogical framework I have outlined in this paper so far. However, as a therapist I cannot speak from the client’s perspective, if I want to respect the client’s otherness. So ethically the therapist’s perspective is the only perspective I can speak from. There is a practical reason too why I speak from the perspective of the therapist: as a MFT supervisor and trainer I am always looking for ways in which I can teach young therapists how to survive in therapy practice, and if possible, to do a good job. Efforts of therapists to do a good job, in my opinion, always have to start from their own perspective and what they can change in themselves or in their positioning, in order to create space for the clients to tell their stories and to gain some kind of understanding and agency in their lives. It is important to realise, however, that no image created from Bakhtin’s *I-for-myself* and the *other-for-me* positions is ever finalised (Bakhtin, 1993). It is at best partial as it misses the surplus that a *me-for-another* perspective can offer (Morson & Emerson, 1990).

The Case-Study

Marital therapy practice

When the marital therapist meets a family for the first time, he/she is faced with a big challenge. The clients come to him/her as a couple, not as individuals. This is expressed in their talking at the beginning of the first session – they often start to talk in terms of *we*, referring to the couple. The division is between *we* (couple) and *you* (therapist): At that moment the therapist is the couple’s other, and the couple is the therapist’s other.

But very soon in the session (sometimes after only a few seconds), when the therapist and the clients exchange their first words, a relationship starts to build in which difference in the couple gradually appears. Otherness within the couple system starts to emerge. In the beginning of the first session this very often has to do with the difference between the partners in terms of commitment to therapy. While both partners come to therapy there is usually one who has a more outspoken concern about the relationship and has taken the initiative to make the appointment with the therapist. The other partner usually has been asked to come along, or even more than this, has had to be convinced, talked into, coerced or seduced into attending.

In this dynamic, the couple’s ambivalence towards therapy surfaces. One partner says ‘Yes’ to therapy in one form or another, another partner says ‘No.’ The ‘No’ can be expressed in a myriad of ways. It can be a sigh, a hesitation, an open rejection of therapy, a reluctance to speak, and so on. However it is expressed, therapists often sense who in the couple is ready to start to tell their stories, and who is reluctant. Often from the very beginning of the very first session the challenge is how to create out of this context of ambivalence a dialogical space in which the multiple voices can be heard, including those of the more reluctant partner?

The case of John and Tina¹

John and Tina come to therapy for the first time. I meet them in the waiting room and Tina looks sad and withdrawn, but she comes to me to shake my hand. In a subdued way she seems pleased to see me. It is as if she has been waiting a long time for this moment. John however is more reluctant to stand up and shake hands.

We go to the therapy room and I introduce myself. I sense that Tina is interested in what I'm saying, while John seems to remain distant and aloof. When I ask them who took the initiative to contact me, Tina says, 'I did.' I hear her eagerness to answer and I sense that she is poised to start to explain why she thinks therapy is needed.

In the vignette, the therapist senses John's 'No' in his reluctance to stand up, to shake hands and to follow the therapist to the consultation room. The therapist can also sense it in the way John listens to the therapist when he introduces himself. Tina on the other hand, in a restrained way seems to be eager to start with the therapy. It seems that she has a lot on her mind and that she wants to share it with the therapist.

For the therapist, it would be very easy to open dialogical space for Tina's story. She appears to be eager to explain why she thinks therapy is necessary for the couple and to reveal some of the ways in which the couple has struggled to survive. The telling of Tina's story would legitimate the meeting as a therapeutic meeting: A dialogical space would be created in which Tina is positioned as the client in need of a listening ear, and the therapist is positioned as a professional listener open to her story. Needless to say, for the therapist this is a comfortable positioning, as it offers the therapist the possibility of assuming his preferred identity in the therapy context, that of benevolent and skilled helper. It would appear that in both Tina's and the therapist's inner conversations a picture is beginning to take shape of a fruitful therapeutic encounter.

However, therein lies the trap. In this picture there is no place for John and his otherness. Such a dialogical space would exclude him. Ethically this is unacceptable but also therapeutically there is a problem. If John is, as he appears, already reluctant to attend therapy, it would appear that he would only become more reluctant if Tina begins by telling her story. This is especially so if she gives an account of all that went wrong in their marriage for so many years, and shares things with the therapist about their intimate relationship before John has had a chance to choose this exchange for himself. It is possible that John would feel subtly exposed or even violated by Tina's story. He might feel pinned down in an identity that he does not recognise as his own. This would only push him into a more defensive position, increasing his reluctance to choose therapy and decreasing the chances of an effective couples therapy.

When Tina says, 'I did,' in reply to the therapist's question about the initiative to make an appointment, she glances at John. The therapist wonders if there is a reproach in that glance.

The therapist then turns to John and asks him, 'Was it difficult for your wife to convince you that therapy might be a good idea for you?'

'Well no. . . . I mean yes . . . At first I did not want to come,' replies John.

This is an important moment, because these questions of the therapist offer him the opportunity to relate in practice to a real experience of otherness. John's

hesitations about therapy express his otherness in comparison with his wife (who really wants therapy). However, it also expresses his otherness from the therapist. As John does not seem eager to take the position of a help-seeker, he denies the therapist the position of a potential helper. This is a very delicate process, because if the therapist is not positioned as a helper, how is he positioned? How does John see the therapist? Making room for the otherness of John may be experienced as threatening for the therapist's identity within the therapeutic dialogue. No wonder it feels uncomfortable for the therapist when he tries to open space in which John's otherness can be expressed.

'Can you help me to understand your hesitation to come?' the therapist asks.

John looks at his wife. Then he says, 'Therapy is just not for me. We should be able find a solution for our problems ourselves. And also, therapy doesn't help.'

'It doesn't help?'

'Well, that's my experience anyway. We went to a couples therapist two years ago and it did not do us any good.'

This is what often happens in therapy. Behind the client's hesitations towards therapy there are stories about earlier attempts to find help or to find relief that turn out to be disappointing. This can be about previous conversations between the partners that only led to more conflict or pain, but it can also be about conversations with professional helpers (such as the GP, the counsellor, the priest, the therapist). Acknowledging the client's hesitations and making room to talk about these disappointing experiences can create room for new experiences and open space to consider new choices. This is illustrated in the next sequence of the session under consideration:

The therapist asks John to talk about the previous therapy.

John talks about his experience of couple therapy with a female therapist and he says, 'All she did was listen. She didn't say anything. We had to pay her and she did not do anything.'

'You would expect more than listening from your therapist?'

'Yes, I would at least want to hear what my therapist is thinking. But that was not the only thing. Even more important was that she sided with my wife against me. My wife felt understood by her, but I could feel her becoming irritated with me.'

'So you want this therapist to share his ideas with you and you don't want him to side with your wife against you. You too want to be understood?'

'Yes. I think she thought of me as being very rational and she wanted me to share my feelings. And that is what my wife has been saying all the time.'

The exploration of John's previous experiences with therapy positions him as someone with legitimate feelings and preferences. Through recounting his experiences John becomes someone present in the session. Furthermore, this sequence of the conversation, while acknowledging John's reluctance, positions the therapist as potentially different from the previous therapist. It opens space for the possibility that some therapists might share their ideas and that some therapists might understand him as well as his wife.

While we can easily see the advantages of making room for John's reluctance for therapy in terms of John's positioning, the therapist has to be aware that this is also a test of Tina's patience. From the beginning of the session, she is eager to start to talk about what brings her to therapy, and John's talking about his experiences in the previous therapy may only be evidence for her of his unwillingness to talk about the real issues in the relationship. It is important that the therapist moves to bring balance by giving Tina space to tell her story.

Discussion

Alliance building in marital therapy

Psychotherapy research suggests that alliance building may be one of the most important therapeutic tasks of the first session of marital therapy (Knobloch-Fedders, Pinsof & Mann, 2004). However, in marital therapy alliance building has its potential complications (Moynihan & Adams, 2007; Thomas, Werner-Wilson & Murphy, 2005). When a couple begins therapy, there is usually one partner who took takes/has taken the initiative, and the other partner who hesitates more, or says 'No' more or less explicitly. As the case of Tina and John illustrates, the danger is that the therapist starts to build a therapeutic alliance with one partner by going into the problem description and thereby neglects the otherness of the one who is more reluctant to go into therapy. In that way the more reluctant partner is neglected and the power dimension that is so central in troubled human relationships, is not acknowledged.

This is consistent with the analysis of Guilfoyle (2003) about power and dialogue in therapeutic relationships in MFT. According to Guilfoyle, the *not knowing* concept suggests that power is a threat to dialogue, and should be avoided in the therapeutic relationship. As a consequence, some therapists relying on the *not knowing* concept go so far as denying the presence of power in their encounter with the client. However, in denying a place for power in the therapeutic relationship, and assuming a virginal ethical position of dialogue as a stable relationship of understanding, the possibility of the client's resistance to power is not acknowledged. Based on his reading of Foucault, Guilfoyle (2003) stresses the importance of resistance as a condition of dialogue: 'Dialogue, in other words, does not require the removal of power operations or rhetoric. It does however require resistance to the exercise of power' (p. 335). In this way, like other theorists of dialogue such as Marková (2003) and Linell (2009), Guilfoyle positions tension as the core of dialogue. In a dialogical understanding, it is only by acknowledging the importance of power, and opening space for the client's resistance (for the client's 'No') that a dialogical meeting can be obtained.

In addition to Guilfoyle's objections to the way the *not knowing* concept is used as a disavowal of power in the therapeutic encounter, our analysis suggests that the concept also risks insufficiently addressing the specificity of the MFT meeting as a multi-actor meeting, as a tension filled meeting. In such a meeting the therapist is emotionally pushed and pulled by the different family members to take certain positions and to acknowledge certain truths. The therapist cannot afford the ethical innocence of *not knowing* as a passive receptive stance, because such a stance would deny the antagonism (Mouffe, 2005) that exists in most stressed partner relationships. In that way the therapist perpetuates the differences and imbalances already present in the relationship, without addressing them. In terms of Mouffe's view we could say that a

couple therapist needs to find a way to transform the antagonism in the relationship into an agonism, in which tension and conflict are accepted and talked about, and in which the partner can sometimes be seen as an opponent or an adversary, but never as an enemy (Mouffe, 2005).

Husbands and wives

Studies show that men are more reluctant to seek couple therapy than women (Doss, Atkins & Christensen, 2003), and that this gender difference is a complex issue. Three factors seem to be involved: (1) men are generally more reluctant to commit to therapy and women are more psychology minded (Shill & Lumley, 2002); (2) women make more use of external support (Doss et al., 2003); and (3) women expect more from their intimate relationships, and they are barometers of the relationship (Doss et al., 2003). While some studies suggest that for men family-of-origin distress might play a critical role in their reluctance to build an alliance in the beginning of therapy (Knobloch-Fedders et al., 2004), other studies point out that men's reluctance for therapy is not attributable to their lack of problem awareness (Moynihan & Adams, 2007). Rather, it seems that men might have concerns about discretion, shame and embarrassment:

Men acknowledge problems but prefer to keep them to themselves. They are culturally conditioned to solve their problems on their own. If men then are reluctant to discuss emotional difficulties or ask for help from close friends, the activity of therapy which requires disclosure to a complete stranger (most often a woman) is likely to meet with stiff resistance. Men may know they are unhappy but they will be dragged kicking and screaming to treatment where they are required to disclose and discuss problems (Moynihan & Adams, 2007, pp. 42–43).

Because of this complexity and the sensitive issues involved, some researchers have recommended that marital therapists need to examine how the decision was made to come to therapy before embarking on a description of the couples' problems (Moynihan & Adams, 2007). Such an examination can create room for the story of the man: his worry that his perspective will not get a fair hearing, his feeling a failure now that they have to ask for help, and his negative experiences with talking about sensitive issues in the relationship. Starting therapy in such a way enhances men's commitment in the early stages of therapy, enhances the therapeutic alliances and reduces the likelihood of their prematurely ending the therapy (Moynihan & Adams, 2007).

Empathic connection with both partners

Regardless of the question of gender and couple therapy discussed above, the learning from the above section can also be considered in relation to the reluctance of either partner to attend therapy and the importance of creating dialogical space in which the more reluctant partner also gets a place. This is all the more important since research seems to suggest that the spouse who is most reluctant to seek therapy might also be the most distressed (Doss et al., 2003). One way to deal with this challenge is to take a shortcut towards a safe and comfortable therapeutic alliance with the willing partner by listening empathically to his/her problem story and adopting a *not knowing* position. In this paper, however, I propose that the therapist take the longer and more difficult route of first making dialogical space for the otherness of the more

reluctant partner. This may lead to a therapeutic alliance in which the therapist has an empathic connection with both partners.

In the case of Tina and John, a crucial moment is when the therapist asks ‘Who took the initiative to make an appointment for marital therapy?’ This question may be counterintuitive for some as it is not focused on the problem that brings the couple to therapy. Some textbooks suggest that the first question in a couple therapy should be: ‘What brings you in today and how can I help you?’ (see, e.g., Patterson et al., 2009). Let us hypothesise for a moment that the therapist asks this question. Certainly this would open up space for Tina’s story and it would offer the therapist an immediate opportunity to adopt a receptive listening stance. However, if the therapist asks this question, he would immediately become aligned with Tina by *implicitly* agreeing with her that it was a good idea to attend therapy. Tina would be positioned as the seeker of help, and the therapist as the provider of help. Here we see Bakhtin’s authoring process (Bakhtin, 1993) in practice: the therapist is the author of a client as his hero, and the client is author of the therapist as her hero. However, within this dynamic, how would John be authored? As the one who does not want help? As the one who does not understand that something is wrong in the relationship? While the question, ‘What brings you in today and how can I help you?’ at that moment in the session may create a dialogical space for Tina, it would only do so by excluding John.

This is what often happens in marital therapy: the therapist succeeds in building an alliance with the partner who is most motivated for therapy. The one who hesitates to commit to therapy or says ‘No’ is then referred to as being ‘negative,’ ‘rigid’ or ‘unreasonable,’ and sometimes he/she is given a psychopathological label that gives the act of exclusion scientific legitimacy. In that way, however, otherness is neglected and the specificity of the therapeutic relationship in MFT, as a tension filled and unstable multi-actor dialogue, is not acknowledged (Paré, 2002).

Major difficulties

In my experience as a clinician and as a trainer, there are two major difficulties for therapists in making space for the ‘No’ of the client. First, the growing frustration of the partner who is most committed to therapy must be kept in mind. Often at the beginning of the first session, when the therapist is exploring the reluctant partner’s good reasons for hesitating to enter therapy (Rober, 2002a, 2002b), the other partner becomes more impatient and shows this in his/her behaviour (e.g., by sighing, looking away). The therapist has to bear this for the time being until a first alliance is made with the reluctant partner, in such a way that he/she will not turn away from therapy further when the problem story is told. Second, it can be difficult for the therapist to resist the temptation to be a good therapist for the partner who is most committed to therapy and who is more than ready to acknowledge the therapist in his/her position as a therapist by telling a story of pain and suffering.

Both difficulties connect with our fantasies as therapists of being benevolent healers (denying our own power and self-interest), and with our professional ideology of testimony as healing (Rober & Seltzer, 2010). We present ourselves as accepting and non-judgmental helpers and we are fiercely committed to creating a therapeutic relationship that will make everything better (Norcross & Farber, 2005). Also, we want our clients to testify about their experiences, as we believe that this may free them of their suffering and pain. However, our invitation to testify can unwittingly represent an act of violence. Sometimes insisting that a client articulates what has remained

unexpressed until now is not done so much for the sake of the testifier or of his/her partner, but in order to acknowledge our identity as professional helpers. Feeling acknowledged as professional helpers, we turn a blind eye to the contextual suffering (e.g. exclusion, pathologising) which is contributed to by such a testimony.

Other kinds of settings

While in this paper we focused on differences in the couple about commitment in therapy, the same dynamics can be found in other kinds of therapy settings, albeit in a slightly different guise. In individual therapy, a similar dynamic can be observed in a client's ambivalence towards therapy as it may surface in the transference relationship with the therapist: 'I want therapy because ... but I don't want therapy because ...' (Engle & Arkowitz, 2006). In family therapy, most of the time, the parents have taken the initiative to phone the therapist for a first appointment, and usually the children come along with some measure of reluctance. The children are there, not because they want to be, nor because they think therapy is necessary or could be potentially useful, but because they have to. In this family dynamic, the family's ambivalence towards therapy surfaces in a split between parents and children: one parent (or both parents) says 'Yes' to therapy in one form or another, while one of the children (or several children) say 'No,' or are at least hesitant about it. In individual and family therapy, as in couple therapy, it can be wise to postpone exploration of the problem story, and first make dialogical space for the voices of reluctance and hesitation.

Conclusion

Psychotherapy research has consistently pointed out that therapists differ in their effectiveness to affect change (e.g., Beutler et al., 2004; Wampold, 2001, 2006). Miller, Hubble and Duncan (2008) found that superior therapeutic performance stems from an attitude of openness towards the client's corrective feedback about the therapy, and then uses it to guide the therapy. This is also what researchers found when they examined the effect of providing systematic feedback to therapists about the client's progress in therapy: therapy became much more effective (e.g., Lambert et al., 2005; Lambert et al., 2001). An open attitude to the client's feedback supposes active interest of the therapist in the client's otherness and the continued commitment to creating a dialogical space in which the client feels legitimised to say 'No' to the therapist, and in which the therapist values this 'No' and uses it to guide his/her actions in therapy by the feedback he/she receives from the clients.

In this paper I have concentrated on the complexity of the specific setting of MFT and I have micro analysed one instance in which the otherness of the client surfaces in marital and family therapy: the more reluctant client's 'No' to therapy in the first meeting, expressed as reluctance, hesitation or resistance, and observed in the differences between the partners about commitment in marital therapy. Analysis of the first minutes in the first session of the marital therapy with Tina and John illustrates the challenges for the couple therapist and some of the ways to deal with these challenges. It shows that a therapist who adopts a receptive stance too early in the first marital therapy session can reinforce an already existing imbalance in the couple: one partner is more motivated for therapy, while the other is more reluctant to commit to therapy. To deal with this imbalance in the couple, the therapist has to position him/

herself in such a way that the otherness of the more reluctant partner is acknowledged, making room for this partner as another human being with a rich inner life filled with personal stories and a meaningful experience.

Dealing with the challenge of the otherness of each partner is an unfinalisable project that continues throughout the whole therapy. It is never finished because a tension between expression and non-expression is always present. In this paper I claim however, that dealing with this challenge presents itself already in the first minutes of the first meeting, and that acknowledging the otherness of the other at that moment can lead to a therapeutic alliance in which the therapist has an empathic connection with both partners. Conversely, it is also possible that making room for the otherness of each partner might uncover insurmountable differences between them, or between one of the partners and the therapist. As explained above, in marital and family therapy, tension and conflict come with the territory, and sometimes instability and nervousness can be so overpowering that a constructive dialogue is not likely to occur.

For Bakhtin, disorder is a given, and wholeness is a project that needs work and attention. For him, the natural state of things is mess (Morson & Emerson, 1990). This is often forgotten by marital and family therapists who use Bakhtin's ideas to support an idealistic view of dialogue as a natural state of equilibrium that can be observed whenever the therapist does not use an expert position to interfere with the system, but rather merely listens receptively to the client's stories.

In this paper, starting from the specificity of the MFT setting I affirm that the domain of human relationships is one where we should always expect antagonism (Mouffe, 2005) and discord. While, as I have claimed in this paper, acknowledging the antagonistic dimension of intimate human relationships may be a pre-requisite for dialogue, consensus and understanding, we have to bear in mind the possibility that sometimes the outcome of a therapeutic conversation may not be consensus, or some kind of understanding. Sometimes we have to be content with an outcome that is mere recognition of the fundamental otherness of the other, without the relief of a compromise or a solution.

Some of the thoughts presented in this paper touch upon our very identity as therapists. We all want to be helpers (Norcross & Farber, 2005), and we all want to relieve our clients of their pain and suffering. Questioning the therapeutic effectiveness of egalitarian intentions and stripping away the idealistic view of the naturally healing dialogue, may confront us with our own uncertainty and powerlessness as therapists. We are confronted with the fact that our individual well-meaning intentions do not transcend the pervasive power balances at play in the broader context. Furthermore, we are confronted by our ethical duty as therapists. We find ourselves in the uncomfortable position of having to find ways to actively contribute to a helpful dialogue when this is not a natural given at all, but rather a project.

Endnote

¹ Not their real names.

References

- Anderson, H. (1997). *Conversation, Language and Possibilities: A Postmodern Approach to Therapy*. New York: Basic Books.

- Anderson, H. (2012). Collaborative relationships and dialogic conversations: Ideas for a relationally responsive practice. *Family Process*, 51, 8–24.
- Anderson, H., & Goolishian, H. (1992). The client is the expert: A not knowing approach to therapy, in S. McNamee & K.J. Gergen (Eds.), *Therapy as Social Construction* (pp. 25–39). London: Sage.
- Bakhtin, M. (1981). *The Dialogic Imagination*. Austin, TX: University of Texas Press.
- Bakhtin, M. (1984). *Problems of Dostoevsky's Poetics*. Minneapolis: University of Minneapolis Press.
- Bakhtin, M. (1986). *Speech Genres & Other Late Essays*. Austin, TX: University of Texas Press.
- Bakhtin, M. (1993). *Towards a Philosophy of the Act*. Austin, TX: University of Texas Press.
- Baxter, L.A. (2004). Dialogues of relating, in R. Anderson, L.A. Baxter & K.N. Cissna (Eds.), *Dialogue: Theorizing Difference in Communication Studies* (pp. 107–124). London: Sage.
- Baxter, L.A., & Montgomery, B.M. (1996). *Relating: Dialogues & Dialectics*. New York: Guilford Press.
- Beutler, L.E., Malik, M.L., Alimohamed, S., Harwood, T.M., Talebi, H., Noble, S., & Wong, E. (2004). Therapist variables, in M.J. Lambert (Ed.), *Bergin and Garfield's Handbook of Psychotherapy and Behavior Change* (pp. 227–306). New York: Wiley.
- Billig, M. (1996). *Arguing and Thinking: A Rhetorical Approach to Social Psychology* (2nd ed.). Cambridge, MA: Cambridge University Press.
- Carr, A. (2009a). The effectiveness of family therapy and systemic intervention for child focused problems. *Journal of Family Therapy*, 31, 3–45.
- Carr, A. (2009b). The effectiveness of family therapy and systemic intervention for adult-focused problems. *Journal of Family Therapy*, 31, 46–74.
- Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. Paper downloaded from the internet: <http://www.massey.ac.nz/~alock/position/position.htm> on January 4th 2006.
- Doss, B.D., Atkins, D.C., & Christensen, A. (2003). Who's dragging their feet? Husbands and wives seeking marital therapy. *Journal of Marital & Family Therapy*, 29, 165–177.
- Emerson, C. (1997). *The First Hundred Years of Mikhail Bakhtin*. Princeton, NJ: Princeton University Press.
- Engle, D.E., & Arkowitz, H. (2006). *Ambivalence in Psychotherapy*. New York: Guilford.
- Fogel, A. (1985). *Coercion to Speak, Conrad's Poetics of Dialogue*. Harvard, MA: Harvard University Press.
- Fogel, A. (1989). Coerced speech and the Oedipus Dialogue Complex, in G.L. Morson & C. Emerson (Eds.), *Rethinking Mikhail Bakhtin* (pp 173–196). New York: Vintage Books.
- Gergen, K.J. (1999). *An Invitation to Social Construction*. London: Sage.
- Guilfoyle, M. (2003). Dialogue and power: A critical analysis of power in dialogical therapy. *Family Process*, 42, 331–343.
- Harré, R., & Van Langenhove, L. (Eds.) (1999). *Positioning Theory*. Oxford, UK: Blackwell.
- Hoffman, L. (1981). *Foundations of Family Therapy*. New York: Basic Books.
- Knobloch-Fedders, L., Pinsof, W.M., & Mann, B.J. (2004). The formation of the therapeutic alliance in couple therapy. *Family Process*, 43, 425–442.
- Lambert, M.J., Whipple, J.L., Smart, D.W., Vermeersch, D.A., Nielsen, S.L., & Hawkins, E.J. (2001). The effects of providing therapists with feedback on patient progress during psychotherapy: Are outcomes enhanced? *Psychotherapy Research*, 11(1), 49–68.
- Lambert, M.J., Harmon, C., Slade, K., Whipple, J.L., & Hawkins, E.J. (2005). Providing feedback to psychotherapists on their patients' progress: Clinical results and practice suggestions. *Journal of Clinical Psychology*, 61, 165–174.

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- Larner, G. (1999). Derrida and the deconstruction of power as context and topic in therapy, in I. Parker (Ed.), *Deconstructing Psychotherapy* (pp. 39–53). London: Sage.
- Larner, G. (2004). Levinas: Therapy as discourse ethics, in T. Strong & D. Paré (Eds.), *Furthering Talk: Advances in Discursive Therapies* (pp. 15–32). New York: Kluwer Academic/Plenum Publishers.
- Linell, P. (2009). *Rethinking Language, Mind and the World Dialogically: Interactional and Contextual Theories of Human Sense-Making*. Charlotte, NC: Information Age Publishing.
- Marková, I. (2003). *Dialogicality and Social Representations: The Dynamics of Mind*. Cambridge, UK: Cambridge University Press.
- Miller, S.L., Hubble, M., & Duncan, B.L. (2008). Supershrinks, what's the secret of their success? *Psychotherapy in Australia*, 14, 14–22.
- Morson, G.L., & Emerson, C. (1990). *Mikhail Bakhtin: Creation of a Prosaics*. Stanford, CA: Stanford University Press.
- Mouffe, C. (2005). *On the Political*. London: Routledge.
- Moynihan, J., & Adams, J. (2007). What's the problem? A look at men in marital therapy. *The American Journal of Family Therapy*, 35, 41–51.
- Norcross, J.C., & Farber, B.A. (2005). Choosing psychotherapy as a career: Beyond 'I want to help people'. *Journal of Clinical Psychology*, 61, 939–943.
- Paré, D.A. (2002). Discursive Wisdom: Reflections on ethics and therapeutic knowledge. *International Journal of Critical Psychology*, 7, 30–52.
- Patterson, J., Williams, L., Edwards, T.M., Chamov, L., & Grauf-Grounds, C. (2009). *Essential Skills in Family Therapy: From the First Interview to Termination*. New York: Guilford.
- Penn, P., & Frankfurt, M. (1994). Creating a participant text: Writing, multiple voices, narrative multiplicity. *Family Process*, 33, 217–231.
- Rober, P. (2002a). Hesitations and their non-verbal expression in the family therapy session. *Journal of Family Therapy*, 24, 187–204.
- Rober, P. (2002b). Constructive hypothesizing, dialogic understanding, and the therapist's inner conversation: Some ideas about knowing and not knowing in the family therapy session. *Journal of Marital and Family Therapy*, 28, 467–478.
- Rober, P. (2005a). The therapist's self in dialogical family therapy: Some ideas about not knowing and the therapist's inner conversation. *Family Process*, 44, 477–495.
- Rober, P. (2005b). Family therapy as a dialogue of living persons. *Journal of Marital and Family Therapy*, 31, 385–397.
- Rober, P. (2008). The therapist's inner conversation in family therapy practice: Struggling with the complexities of therapeutic encounters with families. *Person-Centered and Experiential Psychotherapies*, 7(4), 245–278.
- Rober, P. (2011). The therapist's experiencing in family therapy practice. *Journal of Family Therapy*, 33, 233–255.
- Rober, P., & De Haene, L. (2013). Hospitality in family therapy practice. *Lecture at the 8th EFTA conference in Istanbul, 25 October 2013*.
- Rober, P., & Seltzer, M. (2010). Avoiding colonizing positions in the therapy room. *Family Process*, 49, 123–137.
- Salgado, J. (2007). The feeling of a dialogical self: Affectivity, agency and otherness, in L.M. Simão & J. Valsiner (Eds.), *Otherness in Question: Labyrinths of the Self* (pp. 53–71). Charlotte, NC: Information Age Publishing.
- Salgado, J., & Gonçalves, M. (2007). The dialogical self: Social, personal, and (un) conscious, in A. Rosa & J. Valsiner (Eds.), *The Cambridge Handbook of Social Cultural Psychology*. Cambridge: Cambridge University Press.

- Seikkula, J., & Olson, M.E. (2003). The open dialogue approach to acute psychosis: Its poetics and micropolitics. *Family Process*, 42, 403–418.
- Seikkula, J., Laitila, A., & Rober, P. (2012). Making sense of multi-actor dialogues in family therapy and network meetings. *Journal of Marital & Family Therapy*, 38, 667–687.
- Seltzer, W., & Seltzer, M. (2000). Tales full of sound and fury: A cultural approach to family therapeutic work and research in rural Scandinavia. *Family Process*, 39, 285–306.
- Shill, M.A., & Lumley, M.A. (2002). The psychological-mindedness scale: Factor structure, convergent validity and gender in a non-psychiatric sample. *Psychology and Psychotherapy: Theory, Research and Practice*, 75, 131–150.
- Shotter, J. (1993). *Conversational Realities*. London: Sage.
- Sprenkle, D.H., & Blow, A.J. (2004). Common factors and our sacred models. *Journal of Marital and Family Therapy*, 30, 113–129.
- Sprenkle, D.H., Davis, S.D., & Lebow, J.L. (2009). *Common Factors in Couple and Family Therapy: The Overlooked Foundation for Effective Practice*. New York: Guilford.
- Thomas, S.E.G., Werner-Wilson, R.J., & Murphy, M.J. (2005). Influence of therapist and client behaviors on therapy alliance. *Contemporary Family Therapy*, 27, 19–35.
- Vice, S. (1997). *Introducing Bakhtin*. Manchester: Manchester University Press.
- Wampold, B.E. (2001). *The Great Psychotherapy Debate: Models, Methods, and Findings*. Mahwah, NJ: Erlbaum.
- Wampold, B.E. (2006). The psychotherapist, in J.C. Norcross, L.E. Beutler & R.F. Levant (Eds.), *Evidence-Based Practices in Mental Health: Debate and Dialogue on the Fundamental Questions* (pp. 200–208). Washington, DC: American Psychological Association.
- Watzlawick, P., Beavin-Bavelas, J., & Jackson, D. (1967). *Pragmatics of Human Communication – A Study of Interactional Patterns, Pathologies and Paradoxes*. New York: W. W. Norton.
- White, M., & Epston, D. (1990). *Narrative Means to Therapeutic Ends*. New York: Norton.
- Winnicott, D.W. (1958). *Collected Papers. Through Paediatrics to Psycho-Analysis*. London: Tavistock Publications.
- Wortham, A. (2001). *Narratives in Action: A Strategy for Research and Analysis*. New York: Teachers College Press.