

Deconstruction and the ethical relation in therapy

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Certificate of Authorship/Originality

I certify that the work in this thesis has not previously been submitted for a degree, nor has it been submitted as part of requirements of any other degree except as fully acknowledged within the text.

I also certify that the thesis has been written by me. Any help that I have received in my research work and the preparation of the thesis itself has been acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

Glenn Larner

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Abstract

This thesis explores the ethical relation in therapy in two parallel but connected themes or movements. The first deconstructs an epistemological breach between modern and postmodern paradigms in therapy that has divided practitioners over two decades. This sets modern, scientific or evidence-based knowledge against a postmodern therapy based on narrative, dialogic and relational forms of knowing. Drawing on the philosophy of Derrida and Levinas the thesis proposes the ethical relation as a third path or way of bringing the polarized theoretical positions of the modern/postmodern into dialogue with each other.

I call this ethical positioning towards modern and postmodern knowledge and theory *paramodern*, which means both beside *and* beyond at the same time. It moves the focus from fruitless debates about epistemology or whether knowledge is modern *or* postmodern, scientific or relational etc. to the issue of how it is *applied* in the ethical relation. Such a stance allows therapy practitioners to access a broad range of knowledge, models and techniques. It defines an ethical and integrative approach to therapy that is at once scientific, evidence-informed, practice-based *and* richly grounded in relational, dialogic and narrative perspectives. In the thesis this integrative ethical model is applied to various clinical issues like adolescent depression.

The second theme of the thesis draws on Levinas and Derrida's commentary on his ethical philosophy to ground the self, therapy and the therapeutic relationship in the ethical relation. It argues the ethical is central to the framing of therapy whatever the theory or approach. Both these themes are connected in the overall argument that to deconstruct *is* to be ethical and vice-versa.

The thesis draws on my experience as a practitioner, teacher and author in the field of family therapy over more than two decades. While a theoretical enquiry it is illustrated throughout by constructed examples of therapy practice. The main body of the thesis consists of eight chapters written for publication (chapters 2-9), six as articles in peer-reviewed family therapy/ psychology journals and two as book chapters. All of these have been published except for chapter 2 which is in the process of submission and chapter 3 which has been accepted for publication. Within this framework the introductory Chapter 1 provides a detailed synopsis of the author's previous publications with a commentary on their links to the thesis and describes how the thesis is presented and structured. The final chapter 10 summarizes and reflects on what the thesis has achieved.

Chapter 1: Deconstructing Therapy: a Synopsis of Previous Publications

This introductory chapter presents a detailed synopsis of the author's previous publications, which includes a brief commentary that connects each of these writings to the thesis and its various chapters. It then briefly describes the structure of the thesis in relation to the theme of deconstructing therapy in the ethical relation.

A synopsis of my previous publications achieves three objectives. The first is to provide a historical context for the thesis, one which locates it in terms of my previous thinking and demonstrates links to a prior body of work. The second is to provide a philosophical and theoretical foundation for the thesis, namely Derridean deconstruction, as a platform from which to launch a more focused study of the ethical relation in therapy. The third is to construct a reflective space that allows an opportunity to take stock and consider how my writing and thinking has evolved over nearly two decades of research.

List of previous publications

The 12 publications leading up to the thesis were written between 1991 and 2004 as follows:

1. Lerner, G. (1991). Tolstoy and the Heroes of Family Therapy. *Australian and New Zealand Journal of Family Therapy*, 12, 61-67.

2. Larner, G. (1994). Para-Modern family therapy: Deconstructing post-modernism. *Australian and New Zealand Journal of Family Therapy*, 15:11-16.
3. Larner, G. (1994). A miracle metaphor for family therapy. *Australian and New Zealand Journal of Family Therapy*, **15**: 208-214.
4. Larner, G. (1995). The real as illusion: Deconstructing power in family therapy. *Journal of Family Therapy*, 17:191-217.
5. Larner, G. (1996). Narrative Child Family Therapy. *Family Process*, 35:423-440.
6. Larner, G. (1998). Through a Glass Darkly: Narrative as Destiny. *Theory and Psychology*, 8:549-572.
7. Larner, G. (1999). Derrida and the deconstruction of power as as context and topic in therapy. Chapter X in I. Parker (Ed.), *deconstructing psychotherapy*. London: Sage.
8. Larner, G. (2000). Towards a Common Ground in Psychoanalysis and Family Therapy. *The Journal of Family Therapy*, 22: 61-82. (U.K.).
9. Larner, G. (2001). The Critical-Practitioner Model in Therapy. *Australian Psychologist*, 36: 36-43.
10. Larner, G. (2002). Towards a critical therapy. *The International Journal of Critical Psychology*, 6:9-29.

11.Larner, G. (2003). Integrating family therapy in child and adolescent mental health practice: an ethic of hospitality. *Australian and New Zealand Journal of Family Therapy*, 24:211-219.

12.Larner, G. (2004a). Family therapy and the politics of evidence. *Journal of Family Therapy*, 26:17-39.

There are several ways one could approach a classification of the above papers, however in a nutshell they all apply Derrida's philosophy of deconstruction to key theory and practice issues in psychology, therapy and family therapy. At a practice level they attempt to articulate a common ground between traditionally opposed approaches to therapy, like family therapy and psychoanalysis in papers 5 and 8, or family therapy and cognitive-behavioural therapy in paper 11. At a more theoretical level they seek to redress the schism between modern/postmodern paradigms, which is a legacy of the 1990's and still evident today. Such controversies include the question of epistemology and the therapist's use of knowledge, influence and power in the therapeutic relationship.

As the titles of papers 2, 4, 7, 9, and 10 suggest, their focus is the deconstruction of knowledge and power in therapy, whether it is modern or postmodern. Others like paper 12 map out a third deconstructive way between a modern scientific and evidence-based family therapy and postmodern narrative, dialogic and social constructionist metaphors. Papers 1, 3 and 6 use literary and

narrative metaphors like narrative, fate, miracle and destiny to deconstruct the process of therapeutic change as *other* or falling outside a theory or technology of therapy.

As the following synopsis illustrates, these previous publications challenge both modern and postmodern therapy paradigms from the perspective of Derridean deconstruction. The latter provides a theoretical foundation or scaffolding that allows the author to take a new direction in the exploration of the ethical relation in therapy. While this ethical theme is anticipated in my previous writings, in the thesis it is the centrepiece around which the various chapters are constructed and hang together. This mirrors the stronger ethical focus of Derrida's more recent writings under the influence of his acknowledged mentor, the philosopher Emmanuel Levinas. Indeed where the previous publications can be seen to apply deconstruction to therapy, the thesis writings go on to research the implications of Levinas and Derrida's interpretation of the latter for an ethical approach.

In the following pages I present a detailed summary of the main ideas of each of the 12 previous publications. For each publication there is a self-contained synopsis and argument based on the original paper, which includes a brief commentary and reflection linking it to the thesis theme of the ethical relation in therapy. Citations or quotes from the author are from the original paper and the references are not given again here. References citing other authors can also be found in the original text. However new references

introduced as part of the current commentary are indicated in italics and appear in a reference list at the end of this chapter.

1. *Tolstoy and the Heroes of Family Therapy (Larner, 1991)*

This first publication uses philosophy and literature, in particular Tolstoy's novel *War and Peace*, as a vehicle to critically discuss postmodern developments in family therapy, which had recently had an impact on the discipline. The paper begins with Derrida's observation that deconstruction is most likely to be found at work in the language play of literary works. From there the author suggests that reading literature helps family therapists to be more playful, imaginative and flexible in relation to theory. It enlarges 'the basket of metaphors' and ideas from which therapists can draw in attempting to understand and empathise with human suffering. Literature helps therapists to temporarily step outside established theory and practice boundaries of the discipline, providing a wider perspective that allows them to "read the notes in the margin, 'as well' " (p. 62). For example, inspired by narrative and literary notions of fate, destiny and change, therapists can develop a poetic sense of wonder about what happens in people's lives.

In his novel Tolstoy debunked a simplistic linear-causal explanation of history as the singular intervention of powerful mythical 'heroes' like Napoleon. He proposed a more organic and systemic connection between events that occur through the play of providence, chance or coincidence. Tolstoy presented Napoleon's rise to greatness as the result of a fortunate co-incidence

of life and historical events, where basically he was the right person at the right time. Likewise significant battles are won less by strategy than by luck. Here the outcome of a seemingly minor skirmish in one corner of a battle field, such as a well-positioned battery placement, can have systemic consequences that affect the whole encounter between armies.

The paper suggests parallels between Tolstoy and a postmodern perspective in therapy, which challenged the modern strategic notion of a ‘hero-therapist’ intervening powerfully on a family system. Like history for Tolstoy, change in family therapy could be seen less as planned or controlled by the therapist and more as a random event reflecting a wider systemic process. It is not just about therapists influencing others through the use of a modern scientific technology. Rather it co-evolves more organically and aesthetically through the interaction and dialogue between the various participants.

In this sense the paper suggests the postmodern family therapist is much like the edifying philosopher, as described by the American pragmatist philosopher Richard Rorty. Both see their discipline not as a systematic science that comes to a *final* truth or meaning, but as a social practice or narrative that keeps the conversation going. Or following Wittgenstein, philosophy is a kind of therapy that undoes the knots in our thinking to open up fresh perspectives. Likewise therapy is a kind of philosophy or thinking that uses language to interpret new meaning and context. What postmodern family therapists, edifying philosophers and Tolstoy all have in common is the idea that truth is not an essence but a

positioning or stance, interpretation, narrative, kind of writing, description, conversation, language game or metaphor.

However as I point out, there is an interesting paradox involved here. Namely that a postmodern, systemic, narrative, metaphorical or edifying view of reality cannot itself be *true*, which still leaves open the possibility of modernity as an alternative discourse. Somehow the postmodern idea of *many* truths has to allow for the notion of scientific truth, which represents the real world as modernists believe. In other words, “modernism and postmodernism dance together” (p.66), much like the play of ideas in literature and both lenses are needed to do justice to the complexity of thought, life and therapy. This allows the conversation between modernists and postmodernists in family therapy to go on.

Commentary

Currently this conversation is still occurring, which is why this paper is still relevant to the thesis. As I will argue in chapter 2 of the thesis *Deconstructing theory: towards an ethical therapy*, which concerns how to cross the modern/postmodern divide, contemporary practitioners influenced by the social constructionist ‘turn’ to narrative, dialogue and language have recently been required to take on board modern scientific and evidence-based developments in their discipline. How such integration or rapprochement is possible in theory and practice is a central concern of the thesis. As prefigured in this paper, where

theory is deconstructed or approached as a literary play of ideas, both modern and postmodern perspectives can sit or ‘dance’ together.

This theory position is described in the thesis as adopting an ethical stance towards theory and knowledge or an ethic of hospitality towards the various languages that therapists use. Thus in chapter 4 it is discussed in terms of the ethical play of *irreverence*. This links the notion of theory irreverence espoused by Cecchin, Ray and Lane (1993) in contemporary systemic therapy to Derrida’s thinking about deconstruction as an ethical play of ideas.

2. *Para-Modern Family Therapy: Deconstructing Postmodernism (Larner, 1994a).*

This second publication further develops the integrative motif using the deconstructive philosophy of Derrida. At the time it was actually used by the pre-eminent philosopher Christopher Norris with his graduate class in Applied Ethics. The paper addresses an emerging split within the family therapy field at the time. This was between traditionalists and modernists who believed in the therapist’s power to intervene in family systems and postmodern theorists. The latter such as Goolishian and Anderson (1992) put language, hermeneutics, not-knowing and discourse at the centre of the family therapist enterprise. In doing so they urged family therapists to abandon the modern cybernetic and systemic foundations of their discipline in favour of a narrative and social constructionist paradigm. This is a position still held to the current time (c.f. Anderson, 2005; Anderson and Gehart, 2007; Anderson, 2009).

The paper proposes a deconstructive third term or way between the modern and postmodern, which better reflects the stance of therapy practitioners who pragmatically draw from both traditions despite the theory tension. This is called *paramodern*, where the prefix *para* means both sitting beside (e.g. paramedic) *and* going beyond (e.g. paranormal) at the same time: “The *paramodern* is both the modern and the postmodern. It is neither one nor the other, but both/and” (p.14). The use of this neologism emphasizes the distinction between Derridean deconstruction and a postmodern position and raises the possibility of deconstructing postmodernism.

A paramodern position reflects Derrida’s oft repeated assertions that deconstruction is not oppositional, ideological or *post-modern*. Unlike what postmodernists advocate in family therapy, it does not attempt to undo, debunk, break with, move on from or replace a modern philosophy of language and meaning. For Derrida this is impossible as the latter provides the tools that allow us to think, argue and do philosophy. Rather he respects, engages with and even ‘loves’ the modern thinkers like Freud and Heidegger he deconstructs. Derrida doesn’t seek to destroy, abandon or reject their thought as ‘modern’, but illustrates an alternative, marginalised and co-existing story line already at play within the text.

To deconstruct postmodernism is to show (following Derrida) that it is really an inverted modernism; it is still caught within a modern metaphysics or binary logic or way of thinking it can never quite escape. As I say in the paper: “The

deconstructive lesson for post-modernists in family therapy is that we cannot simply abandon modern ideas of truth and reality, just as we cannot shift or move beyond power and cybernetics. If we attempt to banish modern thought, it merely comes in by the back door” (p.14). This is where postmodern talk in family therapy of overthrowing paradigms and shifts or moves is still cybernetic. It risks becoming yet another dominant ideology, as in George Orwell’s *Animal Farm*, “another grand story to believe in after the purging of the old modernist tale” (p. 13).

I argue that for Derrida what is deconstructed is not modernism per se, but the very opposition, hierarchy, divisiveness and violence of theory it enacts, which is still evident when postmodern therapists propose ‘moving on’ to another paradigm. Here binaries like the constructed/real are simply turned, “upside down, privileging language, meaning and discourse over the ‘real’ and the ‘true’” (p.13). By contrast, literature is deconstructive because it challenges the ideology of theory adopting a playful stance that allows you to ‘say everything’. It provides ‘an experience of the impossible’, which mirrors the complex and paradoxical nature of life and therapy.

To deconstruct the modern/postmodern debate is to argue for their co-existence as theory positions. This reflects what happens in family therapy practice, where the real and constructed, scientific knowledge and discourse, systemic and social constructionist frameworks sit side by side. Here as the paper illustrates, a *paramodern* stance is already at work in the family therapy

literature. For example, where various theorists like Speed (1991), Sheinberg (1992) and Flaskas (1989) integrate social constructionist and realist thinking within systemic, feminist and psychoanalytic approaches to family therapy. In a deconstructed family therapy, modern systemic and postmodern social constructionist metaphors co-exist, with therapists working out of both these frameworks at once.

Commentary

In many ways this article is the pivot on which the argument for the ethical relation in therapy still turns. For example, chapters 2 and 3 further explore the theory and practice dilemma of how therapists can be both modern *and* postmodern at the same time. It develops the idea of the *paramodern* as an integrative practice model, which draws on Derrida's ideas of an ethic of hospitality and the ethical writings of Levinas. Again in chapters 8 and 9 of the thesis the *paramodern* informs an ethics of practice as an integrative approach to family therapy with chronically ill children and depressed teenagers. Here it provides a beginning point for arguing the pre-eminence of the ethical relation in therapy. This is not surprising as Derrida (1999) has noted on many occasions that the so-called ethical 'turn' in his own writings is a misnomer; that in writing about deconstruction he always had ideas of justice and ethics in mind (Critchley, 2008).

My purpose for this paper was to alert family therapists to the risks of the postmodern becoming yet another ideology, one that effaces what has gone

before in the modern Enlightenment and scientific tradition. The theme of deconstructing post-modernism is intentionally provocative, as a challenge to holding any knowledge or theory position too rigidly. In the thesis this is articulated in terms of giving priority to an ethical stance towards the other and adopting an ethic of hospitality towards the different languages of therapy.

In hindsight some 16 years after the article was written, the idea of the paramodern as a co-existence of modern and postmodern ideas has been vindicated and embraced by various scholars in the field, albeit being called different names. As outlined in the final paper of this synopsis these include notions like theory flexibility (Flaskas), promiscuity (McNamee), and irreverence (Cecchin, Lane and Ray). I believe it can also be found in recent dialogical approaches to family therapy where the *open dialogue* approach of writers like Seikkula and Trimble (2005) sits together with the challenges of scientific research and neurobiology, as outlined in chapter 2 of the thesis. Today as therapists we find ourselves in a post-postmodern (i.e. paramodern) world where a relational and scientific approach to therapy sit side by side.

Postmodernism has now taken its place as *one* of the major ‘schools’ of family therapy with current theory and practice requiring an integrative therapy approach. As chapter 9 of the thesis argues, from an ethical perspective therapists today are required to respond in the most effective way possible to the complex needs of client populations, like depressed adolescents. This gives the *paramodern* a contemporary face, which demonstrates therapists can embrace a

modern evidence-based and scientific paradigm, *while* working within a postmodern social constructionist and relational framework. As I argue in chapter 5 of the thesis, this is achieved by giving priority to the ethical relation, over and above epistemology or theory.

3. *The Miracle of Family Therapy (Larner, 1994b)*

This 3rd publication maps personal change as an unexpected, chance and poetic event that falls from life, one which cannot be totally explained or contained by a theory, science or technology of therapy. It proposes *how* change occurs, whether at the level of the individual in therapy or in the universe is a mystery, which like history for Tolstoy is ‘beyond our ken’. Here it is more fruitful to see the process of change as a deconstructive ‘plurality’ rather than a unity or essence with a single definition or causation. Thus in a person’s life history or narrative, change can follow a vast range of personal experiences and life events, as depicted in film and literature, as well as any number of different therapies.

In other words, change is not “something we simply plan, control or construct in the confines of something we call therapy” but is an extraordinary happening or ‘miracle’ (p.209). The latter is defined in the paper as an unusual, wonderful, marvellous, aberrant, singular and unique event we cannot explain in rational terms. It suggests therapeutic change is an aberration or exception to the rule, coming ‘out of the blue’ to surprise us and breaking into the ordinary or the same as difference or other. Instead of taking it for granted, its occurrence in

a person's life is an "unexpected and rare event worth celebrating" (p.210).

Following Einstein's musings on life and the universe, change inspires a 'holy curiosity'. Or in terms of the French philosopher, Emmanuel Levinas we marvel at the expression of 'infinity in the finite'. As in literature it illustrates a deep connectedness, harmony and beauty of the world, a sense of meaningful coincidence that therapists can only wonder or "ahh" at.

The paper goes on to argue the idea of 'miracle' has been excluded by modern philosophy and science as 'superstitious' or mystical thinking. Especially since the writings of the sceptical 19th century empiricist philosopher David Hume, there had been a conventional wisdom opposing miracles *to* science, reason and the laws of nature. In the binary 'science/miracle' the former term was privileged by a rational and scientific Enlightenment paradigm, with the idea of miracles marginalised and cast into the 'netherland' of human experience.

This is mirrored in research into the effectiveness of therapy based on a scientific understanding. Change that occurs outside therapy is labelled as 'spontaneous remission' or an insignificant random life event. Therapists are led by their own professional and institutional interests to see change causally, following a particular therapeutic intervention rather than being a 'miraculous' or random life phenomenon. This bestows power and authority on the therapist as the agent of change, rather than acknowledging the person's agency to influence their own life narrative.

The paper documents several narrative examples of persons reporting miraculous change in concert with therapy. It suggests therapeutic change be described from a deconstructive position in terms of both science *and* miracles. Here therapists “look for the miraculous in the therapeutic and therapy in the miraculous” (p.211). This creates room for an aesthetic and poetic sensibility in therapy as well as the scientific and rational, which can be seen as *both/and* rather than *either/or* possibilities. The therapist’s agency to help others co-exists with a respect for the sacredness and connectedness of life, with change seen to be co-authored by both technology and miracles.

Commentary

This paper deconstructs the traditional notion of therapeutic change by seeing it not merely as the result of a therapeutic intervention, but as coming from the *other* or unknown. The idea that change transcends what therapists can know or influence in relation to another person reflects a Levinasian understanding of the ethical relation. And here this article anticipates a more detailed exploration of Levinas and the ethical in the thesis. For example, in chapter 5 of the thesis it is argued the *other* as beyond our comprehension is the starting point for all therapeutic discourse. In Chapter 6 this is developed in the notion of therapy providing an ethical container, which intersects Bion’s psychoanalytic thinking with the ethical philosophy of Emmanuel Levinas. My third publication also contained the seed of the argument in the thesis (cf. Chapter 2), that therapists can use both a modern scientific *and* post-modern

relational, dialogic or narrative framework to account for change in people's lives.

4. *The real as illusion: deconstructing power in family therapy (Larner, 1995)*

This article continues the author's project of deconstructing the division between modern and postmodern perspectives in family therapy. It addresses a contentious debate about power in the literature, which is constructed as follows. In what is called a traditional, modern or first-order cybernetic-systems paradigm, power is considered to be real and the therapist's role is prescribed in terms of intervening directly with families in a structural or strategic way. However for second-order family therapists or postmodernist theorists, the idea that therapists act upon and change others is considered to be an error of thinking. It evokes the idea of the powerful 'hero-therapist' discussed in the first paper on Tolstoy. Rather from a more ecological viewpoint therapists are seen as part of the system being observed and unable to change families acting from the outside. Indeed it is the very idea of a firm distinction between the inside/outside that is challenged.

In this debate, following Bateson power can be seen as an epistemological illusion, one which is dissolved once we adopt a wide enough systemic or relational lens. Similarly in a postmodern or social constructionist model, instead of therapists being seen as powerful agents of change they are seen as participants in a co-evolving process between persons. Here they explore

meaning through language, help to co-author new stories and work collaboratively *with* clients rather than upon them. Therapy is seen as a relational and language-based activity where the therapist's power dissolves, as the client is empowered to develop their own agency and expertise.

Well and good but the controversy escalates when post-modern therapists like Anderson and Goolishian (1992) urge family therapists to *replace* a modern-systems-cybernetic paradigm with a narrative social constructionist metaphor. At the same time feminist and Foucauldian-inspired family therapists critique social constructionists for not taking the reality of power in society seriously enough. Violence, patriarchy and sexual abuse in families, economic marginalization, social injustice and political suppression are real enough, which requires therapists to adopt a strong and influential position to counter their effects.

To address this impasse the paper proposed a deconstructive reading of power as a concept that is “both socially constructed *and* refers to what happens in the real world” (p.196). This acknowledges and celebrates the diversity and difference of modern cybernetic *and* postmodern social constructionist visions of therapy. This *double* reading of power was shown to be already at work in the family therapy literature. For example, Cecchin, Lane and Ray's (1993) idea of theory *irreverence* acknowledged the need for both instrumentality *and* non-instrumentality in family therapy. This topic is later directly taken up in chapter 4 of the thesis from the perspective of the ethical relation.

Also the paper suggests in practice, modern therapists sometimes display ‘non-interventive’ and ‘not knowing’ postmodern tendencies. And postmodern therapists like Anderson and Goolishian, while saying they do not believe in power and knowledge *in theory*, nonetheless act as if they do in practice. Following Derrida it would seem that power is impossible to escape whether we believe in it or not. As I put it in the paper: “To say that by not *believing* in the metaphor of power, change occurs more readily, is to believe in power, the power of the therapist to change others by not believing in such power. To believe that change occurs from the therapist being non-influential rather than powerful is to believe paradoxically in the power of nonpower” (p.201).

In other words not-knowing can be seen as a kind of knowing and non-power enacts power at another level. Also a non-interventionist stance in therapy *is* itself a form of intervention. While social constructionists in name “oppose cybernetics, they actually negotiate the border between power and non-power; they know by ‘not knowing’ operating between these dualities” (p.201). Here the paper draws an analogy with Dostoevsky’s novel *The Idiot*, where the ignorant Prince is a savant who knows by not-knowing and is powerful by taking a position of non-power. This double or both/and Derridean deconstructive view of power is then discussed in relation to the ideas of both Bateson and Foucault.

The paper concludes that the problem of power is indisputable; it is impossible not to have a powerful influence on others in therapy. Nonetheless

the more relevant question is whether power, knowledge and technology in therapy is used ethically. Epistemology or theory, that is, whether we adopt a knowledge stance that is modern or postmodern, is less important than an “*ethical* concern for the abuse of knowledge and power for personal, ideological or political ends” (p.206). From this ethical perspective, family therapists straddle the complexity of a modern and postmodern understanding of power. It is not that the real (power) is an illusion as postmodernists say, *or* that the illusory is real as modernists propose, but as for Dostoevsky’s Prince somewhere in-between.

Commentary

If as this paper maintains, we assume therapists cannot avoid being powerful, knowing and influential, the more relevant challenge becomes how to do this in an ethical way. In effect this article first canvassed the idea that epistemology takes second place to the ethical relation in therapy, which is the main theme of the thesis. This is elaborated in chapter 6 as a discussion of discourse ethics in therapy. This proposes the welcome offered to the other in an act of hospitality, takes priority over the particular theory, model or paradigm followed by a therapist. This is the often repeated theme of the thesis, what matters in therapy is less epistemology or what we know and more ethics or *how* we know and use our knowledge in relation to others. Of course this transcends any strict division between modern and postmodern theory and practice, rather as the thesis argues it is the focus of an ethical practice.

5. *Narrative Child Family Therapy (Larner, 1996)*

This article published in the major U.S. family therapy journal *Family Process*, presented a theory and practice model for integrating the historically disparate disciplines of child psychoanalysis and family therapy. It describes both approaches from a narrative and social constructionist perspective as sharing a dialogical and hermeneutic theme of developing meaning, dialogue and understanding in the therapeutic conversation. The author called this narrative child family therapy (NCFT), which is illustrated by two practice examples, one involving Cystic Fibrosis, the other child behavioural problems.

The paper had significant implications for practice by showing that specialist child therapy skills could be integrated as part of an overall family therapy approach. This addressed research in the field, which showed most family therapists talk to adults during family interviews and lack the necessary expertise to engage and involve children, for example, through the use of play and other non-verbal media. The paper also explores a significant dilemma for social constructionist therapists, namely how they can be ‘not-knowing’ and still utilise their previous training, expertise and knowledge in therapy. Following the deconstructive thinking of the articles already discussed, the author argues for the integration of modern and postmodern knowing as part of a *paramodern* approach to therapy.

In the first stage of NCFT the therapist arranges up to three individual play interviews with a child. However unlike traditional child psychoanalysis, the

therapist resists interpreting the child's play and art in the session. Rather the therapeutic stance is not-knowing and dialogic, where: "the therapist creates a space for thought and meaning to develop in the therapeutic relationship. This depends upon the therapist's ability to "not know or to be with and contain the child's emotional pain" (p.430). Applying Bion's idea of containment, it is suggested the therapist constructs a thinking and relational space or container, where the child's uncomfortable feelings can be taken in, held and processed in thought. This provides an opportunity for the therapist to reflect (at this stage inwardly) in the countertransference relationship about possible meanings of the play narrative.

In the second phase of NCFT the child's play and art narrative (with their permission) is taken to a family interview for a wider conversation about its possible meaning and relevance to the presenting problem. Like Hermes the ancient messenger or go-between the gods, the therapist acts as a mediator or carrier of stories and meaning between the child and family. The child's play narrative is actively joined to the family narrative about the problem, which constructs a dialogic space in which relational meaning can emerge. This creates a public space for sharing the child's inner experience or narrative voice by connecting it to the wider systemic world: "The child's symbolic play as narrative is joined to the family story as social text in therapeutic conversation" (p. 436).

However unlike a classic ‘not-knowing’ stance in the social constructionist approach, the therapist’s expertise, meaning and knowledge is used to actively contribute to the family dialogue. Here: “Therapy becomes hermeneutic not by expunging a therapist’s knowledge but by transforming it into a dialogue with others” (p.438). The therapist plays a directing role, first inviting each member of the family to express their meaning about a child’s play narrative or drawing, and then offering their own thoughts, interpretation or psychological meaning where relevant. Here the therapist’s ‘inner talk’ is shared as one possible contribution or opinion in the ‘outer’ conversation with the child and family.

In the paper this therapeutic stance was called *not-knowing knowing*. This highlighted the therapist’s integration of thinking, expertise and knowing as part of a not-knowing or social constructionist therapy approach: “The therapist brings knowledge into the therapeutic conversation as a not-knowing, as part of the desire for inquiry, and to understand more” (426).

Commentary

This integrative model is further developed in paper 8, where the author renames this stance as *knowing not to know*. This explores the common ground between psychoanalysis and family therapy, which is made possible by charting the development of postmodern relational and narrative thinking in both disciplines. In the thesis the idea of *knowing not to know* is developed to map further intersections between psychoanalysis and family therapy. Thus in

chapter 6, it combines the ethical philosophy of Levinas with Bion's psychoanalytic theory of containment. In effect this proposes the thinking container that develops in the dialogue of the therapeutic relationship has an ethical shape or is formed through persons enacting the ethical relation with each other.

6. *Through a Glass Darkly: Narrative as Destiny (Larner, 1998)*

This paper was published in *Theory and Psychology* the major international journal for academics and authors in social constructionist and critical psychology. It explores the concept of narrative in therapy using literary and philosophical notions of fate, chance and destiny.

The paper begins with a literary metaphor from Stendhal in his novel *Scarlet and Black*, where he compares a novel to a mirror carried along the high road of life; at one time it reflects the azure sky and at another the puddles at our feet. The paper suggests unlike therapy, literature doesn't get bogged down in competing discourses or theories, but portrays *everything* about human experience, both the lows *and* highs. By adopting a literary understanding of narrative, therapy can be seen to link "past, present and future in a story of destiny" (p. 550). Here stories of the past contain the seeds of agency and change in the future, which is like looking at a reflection of the sky in a murky puddle, or as St Paul said, for now 'we see through a glass darkly'.

The paper proposes that therapy provides a setting in which a personal life narrative unfolds through the interplay of fate and chance as destiny. On the one

hand there is fate, which like First Cybernetics in family therapy describes the sense in which persons feel trapped in an unchanging relational life pattern or dominant story, one which is beyond their control and keeps things the same. On the other there is chance, which as in Second Cybernetics is the story of the unexpected and unpredictable, where events take persons by surprise and introduce change and difference into relational systems and individual lives.

However following Derrida the fate/chance binary can be deconstructed to show both terms refer to what falls or befalls us. The meaning of one is contained in the other, as fate *falls* through the play of chance and both words are captured in the notion of ‘destiny’. As literary classics like Virgil’s *Aeneid* illustrate, destiny is what is to come that falls upon us, but it also expresses an idea of purpose and human freedom. As I say: “Our destiny befalls us yet we freely choose it and it is not always tragic, which preserves a sense of personal agency” (p.553). Despite the fall of chance and fate, through destiny we live our lives into the future.

The paper suggests the literary notion of destiny is a crucial aspect of narrative that has been neglected in psychology and therapy. It attempts to understand change as “the point where past, present and future narratives meet” (p.557). As in Proust’s novel *Remembrance of Things Past* narrative destiny is a sign of past memory in future time. A future narrative richly resonates with aspects of a person’s past story. This redresses the tendency in postmodern thought to displace or *break* with the past, which may contribute to a sense of a

fragmented or dispersed self. The paper suggests in narrative approaches to therapy, personal agency evolves from the old narrative “like a phoenix from its ashes...The new narrative is interwoven into the family history as a thread connecting a past recruitment or fate with their future destiny” (p.559).

In effect the paper deconstructs the postmodern idea of a decentred self, suggesting there is also a necessity, destiny or centre to a life narrative that constitutes us as persons. Our sense of who we are is not merely random or arbitrary but expresses a ‘narrative as destiny’. From a deconstructive perspective, the relational or socially constructed self still possesses an individual, self-reflecting and coherent identity across time. Thus for Derrida the self is centred *while* decentred in the other, which allows us to be political subjects and take an ethical *position* of responsibility and justice.

In conclusion the paper suggests that persons *fall* into change through the interplay between fate and chance as a narrative of destiny. This is humbling for therapists as therapeutic change occurs in the client’s unique narrative time rather than under the influence or control of a technology of therapy.

Nonetheless several practice examples illustrate how therapy can help or at least be a witness to hope and change in the face of a crushing life story or fate. What therapists say and do can have miraculous, marvellous or poetic consequences for enhancing personal and family destiny.

Commentary

The argument in this paper is that we require a sense of the self as a centred, unified and necessary narrative of destiny, one which is distinct from the postmodern notion of a dispersed, dialogical or multi storied self. This is further developed in the thesis in chapter 7, where the systemic, relational or dialogic self of family therapy is discussed in terms of the ethical self. Basically this follows Derrida's (1999) commentary on Levinas, namely that a strong, unique and coherent sense of personal identity is required in order to take a position of agency and ethical responsibility towards others.

7. *Derrida and the deconstruction of power as context and topic in therapy*
(Larner, 1999)

This invited chapter for an edited book by Ian Parker called *deconstructing psychotherapy*, addresses the complex problem of power in therapy in the context of Derrida's writings on ethics, politics and justice. It continues the author's explorations of this difficult topic in family therapy in the pre-thesis paper 4 above.

The chapter explores the ethical dilemma of how therapists can deconstruct power from a *position* of power. For Derrida to deconstruct is to open up difference as an ethical gesture, which makes space for *many* languages and meanings in a text or narrative, especially those that have been marginalised. However this is only possible by taking a 'forceful' position or stand on justice that mirrors the very power and violence being deconstructed. That is, deconstruction is not a neutral activity but is itself a form of violent (albeit

lesser violent) theory or thinking that cannot avoid attempts to legitimize its own authority and power.

Likewise in postmodern therapy the priority is to construct a therapeutic space in which the client can be heard and empowered to utilise their agency, knowing and expertise for change. However as professionals, therapists cannot avoid taking a position of influence, knowledge and authority that has the potential to negate the voice of the other. Thus: “A therapist takes control of an interview in order to let the other have a voice, to be empowered. For both psychotherapy and deconstruction, the dilemma of power is how to take a position (for example on ethics and justice) when such positioning itself involves a ‘violence that founds or positions’” (p.40). The problem or dilemma of power is how to be knowing and influential in a not-knowing, ethical or non-violent way? It is a question of how to be both powerful *and* not powerful at the same time.

The problem of power is an unavoidable feature of everyday human relations and encounter; indeed Derrida defines deconstruction in terms of being caught within its paradox or *aporia*. In contrast social constructionist therapists attempt to resolve, dissolve or move on from a position of power, hierarchy and knowledge by adopting a not-knowing and dialogic stance. However as Derrida says, power like modernity is not something we can just step out of ‘one fine day’ to replace with something else. As the paper notes: “To deconstruct psychotherapy in the spirit of Derrida, is to purge the cultural idols of power,

technology and mastery from therapy, while acknowledging that we can never quite leave them behind” (p.40).

From a deconstructive perspective therapists work within the paradox that to be ethical *is* a powerful position. The problem of power is embraced and endured as a necessary part of the therapeutic relationship and provides the very context for a deconstructing therapy to proceed. Here therapists are transparent acknowledging their position of power, privilege and expertise as arbiters or representatives of a masterful therapeutic technology. However at the same time they participate in a face-to-face encounter and dialogue that puts the other *first* in the ethical relation: “The conscious movement of the therapist towards the other as an ethical stance allows a true dialogue of unequals, in which both therapist and client are powerful *and* non-powerful” (p.48). The paper concludes the first task of a deconstructing therapy is to deconstruct its own authority and power, both as an ethical stance towards the other in the therapeutic relationship and as a flexible positioning towards theory and knowledge.

Commentary

This paper already begins to explore the ramifications of deconstruction as an ethical position, which is later developed in the thesis as a major theme. For example, in chapters 2 and 3 it is discussed in terms of therapists being required to speak a range of therapeutic languages in order to effectively help their clients, yet the challenge is how avoid imposing these therapeutic discourses on

others. The thesis suggests this is possible where therapy is seen as foremost an ethical activity in relation to others, where the languages that therapists use empower and enable others to form their own language community and discourses for change.

8. Towards a common ground in psychoanalysis and family therapy: on knowing not to know (Larner, 2000)

In many ways this article is a further development of NCFT described in paper 5 above, which combines child/family therapy and psychoanalytic/narrative frameworks. It explores the theoretical common ground between psychoanalysis and family therapy, demonstrating how postmodern relational and narrative thinking has informed both disciplines during the 1990's.

The article begins with a literature review that charts a psychoanalytic 'renaissance' or 'turn' in the discipline of family therapy over the previous decade. This was surprising especially given family therapy largely began in opposition to the predominant psychoanalytic framework of the 1950's and 1960's and subsequent dialogue between the disciplines has been almost non-existent. The paper suggests a possible theoretical ground for rapprochement in the philosophy of deconstruction, which challenges rigid conceptual and theory borders between disciplines. In this way: "Contemporary psychoanalysts and family therapists are currently less bound by the tradition of theory and more informed by an ethic of practice as dialogue and collaboration in the therapeutic encounter" (p.62).

Next the paper explores a corresponding narrative, relational and systemic ‘turn’ in contemporary psychoanalysis. This is demonstrated in its move away from a modernist, individualist and ‘one-person’ philosophy of mind, bringing it closer to a relational perspective. As the paper concludes after a review of the recent psychoanalytic literature: “Contemporary psychoanalysts describe what they do as a narrative journey with the analysand, in which the psychological facts and interpretations are socially constructed in the ‘here and now’ intersubjective experience of the countertransference relationship” (p.66). What is interesting is this mirrored the postmodern and social constructionist movement within family therapy during the 1990’s. Nonetheless family therapists were largely unaware of these postmodern theory developments in their sister therapeutic discipline.

The paper then describes the psychoanalytic enterprise, particularly as it had been influenced by the thinking of Bion, in terms of the analyst’s stance of ‘not-knowing’: “The psychoanalytic interest is the point where knowledge breaks down and becomes unstable as a not-knowing, which is a real knowing at the level of the patient’s unconscious emotional communication” (p.67). This is compared to a not-knowing stance in family therapy from a social constructionist perspective, which “opens a space for conversation around a ‘problem’, so new meanings and narratives can emerge” (p.68).

However it is argued that the posture of the therapist in both family therapy and psychoanalysis actively combines knowing *and* not knowing, where factual

knowledge, technique, interpretation, thinking and expertise is held hand in hand “with a not-knowing receptivity towards the client’s construction of meaning” (p.71). This complex epistemological positioning holds modern and postmodern knowing in tension, one which the paper calls a *paramodern* stance of ‘knowing not know’.

The article further describes this stance in terms of Bion’s notion of ‘containment’. Thus in the psychoanalytic dialogue the analyst’s role is to think, interpret, put into words and contain “the person’s emotional experience so that it can be thought about and understood” (p.73). As in family therapy this involves a collaborative and dialogic exchange between the therapist and client, which constructs a narrative or thinking container for holding painful and emotional meaning –the not yet said-and transforming it into a digestible or coherent story. Here the therapist’s ‘not knowing’ stance, in being curious, receptive to and taking in the other’s meaning so they feel understood, provides a container for ‘knowing’ and thinking to develop in the therapeutic conversation.

As a consequence: “This integration of not knowing and knowing is what a postmodern psychoanalysis has in common with family therapy; both are ways of being with individuals to help them develop and hold their own knowing” (p.79). The article provides a case example, which illustrates ‘knowing not to know’ as ‘containment’. This uses the NCFT approach described in paper 5 above to conclude: “It is this deconstructive interplay between knowing and not

knowing which defines a therapeutic conversation, whether in a narrative or a psychoanalytic context” (p.80). In both psychoanalysis and family therapy, a therapeutic stance of not knowing informs the therapist’s knowing and vice-versa.

Commentary

This paper continues the author’s work of applying Derridean deconstruction to the therapist’s use of epistemology in therapy. Here the concept of ‘knowing not to know’ as containment is used to map a common ground between the seemingly disparate approaches of family therapy and psychoanalysis. This conceptual integration or intersection is further developed in Chapter 6 of the thesis, where it is given an ethical description by bringing Bion’s approach to psychoanalysis into conversation with the ethical philosophy of Levinas. This suggests the therapist’s stance of ‘knowing not to know’ provides a thinking or relational container with an ethical shape. Put simply the thinking that occurs in the therapeutic dialogue is nurtured by being open to the language of the other from a stance of hospitality as ethics. This is the basis for describing the self as ethical in chapter 8 of the thesis.

9. The Critical-Practitioner Model in Therapy (Larner, 2001)

This paper appeared in a special issue of the journal *Australian Psychologist* devoted to taking critical or postmodern psychology to a wider mainstream audience. It argues for a broadening of the scientist-practitioner model in clinical psychology to incorporate humanistic, relational, narrative,

psychodynamic and systemic metaphors. This has links to paper 12, as both address how a postmodern therapy can come to terms with scientific evidence-based practice and how mainstream or modern therapy in turn can open up to relational, dialogic and narrative approaches.

The paper begins with a critique of the scientist-practitioner model, which examines the limitations of outcome research based exclusively on randomised or controlled clinical trial methodology. This acknowledges the complexity of real life therapy in natural settings, where the question of *what works for whom* is often difficult to isolate and answer. Here a major issue is the problem of clinical validity, or “whether standardised psychological treatments investigated under laboratory conditions of experimental control and translated into step-by-step manuals are relevant to what therapists do and clients need in the real world of lived human experience in which clinical practice takes place” (p.37).

Research in clinical settings requires more flexible and qualitative research designs, like single case methodology, to evaluate therapy effectiveness. The select and homogenous populations used in academic research and the ‘purist’ therapy approaches (like cognitive-behavioural therapy) applied to them are almost nonexistent in ordinary clinical practice. For example, in child and adolescent therapy, co-morbid diagnoses and family and peer group influences often complicate a clinical presentation, which demands a more integrative approach from practitioners.

The article argues *what works* in therapy is still formative and an open question. This means singular prescriptions for evidence-based practice at this stage are more a question of political and economic expediency than science. This suggests the relevance of ‘clinical wisdom’ in judging what is going to be effective in therapy, which takes into account the context of therapy and the contribution of a person’s narrative, family and culture. Thus in treating child and adolescent depression, cognitive therapy generally needs to be supplemented by a wider systemic intervention with the family.

The paper argues that ‘best practice’ in clinical psychology requires attunement to the other in the therapeutic relationship, as well as recognition of key therapist variables like empathy, flexibility, creativity and imagination. Instead of “blind adherence to research based manuals and techniques” (p.38), it engages with the client’s language and considers their living and relational context. This recognizes that therapy is an ‘art’ as well as a science.

Taking a deconstructive perspective, the paper does not advocate abandoning the scientist- practitioner model but reconfiguring it, so that it “fits better with what actually happens in clinical practice” (p.39). Far from closing down scientific enquiry, this opens it up; for example, it encourages research into the process of therapy, rather than seeing symptom change as the only possible measure of effective therapy. A critical therapy addresses the emotional, subjective and interpersonal foundations of psychological life through qualitative, collaborative and person-sensitive methodologies: “This extends the

mainstream focus of the psychological study of individuals in isolation from their social, cultural, community and language contexts” (p.40).

A critical-practitioner model in psychology and therapy involves a stance of open enquiry and reflexivity; it questions the politics of its own institution and recognizes the role of taking a theory position in scientific research. Its purpose is to create theory and knowledge diversity *within* a modern science of psychology, rather than to abandon and replace it with a contextual or social constructionist paradigm: “This both/and positioning offers a richer theoretical and practice base for psychology and therapy” (p.40).

Next the article refers to deconstructing the scientist-practitioner model, which is to see both modern *and* postmodern perspectives as complementing and enriching each other. Such a *paramodern* stance better reflects the needs of practitioners in the field: “In the pragmatic world of clinical practice, the flexible integration of models is what many psychology practitioners already achieve, and in this sense they are already deconstructing the profession” (p.41). In hindsight this conclusion has been supported by the recent ‘third wave’ within clinical psychology, which has introduced more integrative therapy approaches, like mindfulness-based cognitive therapy, Acceptance and Commitment Therapy and Dialectical Behaviour Therapy, as described in chapter 2 of the thesis.

Commentary

This article is part of a series reviewed in this synopsis (papers 6, 7, 9 and 10) applying deconstructive thinking to a social constructionist and critical therapy and psychology. This work culminated in a book by the author co-edited with David Pare called *Collaborative Psychology and Therapy in Practice* (Pare and Larner, 2004). It also provided the foundation for paper 12 reviewed later in the synopsis, on the politics of evidence-based practice in family therapy.

The idea of a critical practitioner model informs chapters 2 and 3 of the thesis, in terms of how therapists can utilize both modern *and* postmodern paradigms from the perspective of the ethical relation. It also lays a foundation for the development of an integrative evidence-based approach to family therapy in treating adolescent depression, as described in chapter 9 of the thesis.

10. *Towards a critical therapy (Larner, 2002)*

This article features in a special issue of *The International Journal of Critical Psychology* on therapy. The references to Derrida are contained in the original paper and not listed here. It begins describing a peculiar paradox about critical psychology, namely that while it seeks to address “the violent exclusion of the other from existing psychological discourse (for example, voices of the spirit, body, culture, sexuality and gender), its own poststructuralist or postmodern institution is founded by a violent rupture, namely with the enterprise of modern psychology” (p.9). The question posed is how a critical or postmodern therapy can avoid perpetuating the modern episteme to dominate, colonize, oppose,

marginalize and exclude other voices or points of view in the conversation (albeit in this case the modern).

This postmodern dilemma is a common theme of the author's writings already articulated in terms of the paradoxes of power and knowledge in family therapy. It reflects Derrida's concern with the violence of institutions (academic, professional, cultural, textual and theoretical etc.), which establish their foundations and authority through a process of power and exclusion. As he says: "So the paradox is that the instituting moment of an institution is violent in a way" (p.11). What deconstruction addresses is precisely this violence of the institution, whereby it becomes a 'closed system' of thinking and speaking that justifies its own position by critiquing and suppressing what is different and other.

Now for Derrida such violence is impossible to avoid even for deconstruction, rather the question is how to choose a path that is *less* so. Here he notes: "every philosophy of nonviolence can only choose the lesser violence within an *economy of violence*" (p.11). This defines a strong distinction between post-modernism and deconstruction that is still not widely recognized. For Derrida the term *post*, "introduces yet another theoretical hegemony in the history of thinking, it is a violent periodization that participates in frenzied competition which activates and accelerates the production of titles in "new" and "post-isms"" (p.12).

Unlike postmodernists, Derrida engages with and even ‘loves’ the texts of modern philosophy he deconstructs; such as Descartes whose dualist philosophy of mind and quest for certainty is the bane of social constructionists like Shotter (1999). For Derrida modern thinking and its tools of analysis like logic, science and truth still have currency, which is why he clearly says “to deconstruct is a structuralist and anti-structuralist gesture at the same time” (p.12). Unlike its common perception, deconstruction does not attempt to overthrow and replace modern Enlightenment thought, but to bring out the voices it has marginalized *within* its own system, in effect to open the institution to its own future.

This is the basis for a *paramodern* position that engages with the voices of modern psychology and therapy. The paper provides an example that deconstructs the social constructionist *versus* realist debate in psychology. This provocatively explores the ‘realist’ ontology inherent in the social constructionist position, in so far as it “defines the world as a social construction; it wants to fill reality with the dialogic and the social, so there is no other reality than itself” (p.13). However this is part of the same process of modernity, whereby institutions establish their own foundations by denigrating others in a kind of ritualistic or evolutionary struggle for dominance. It is this form of political hegemony, the notion there is only *one* language or truth (whether realist *or* social constructionist) that Derrida seeks to deconstruct.

Next the critical realist approach of Roy Bhaskar is presented as an example of a deconstructive approach. This holds there is a real world ‘out there’,

independent of observers and able to be scientifically or objectively studied, but our access to it is necessarily mediated through textual, language, cultural and social constructions. This fits with the argument of Christopher Norris, that Derrida like Bhaskar is very much a critical realist.

The paper then suggests to be critical is to deconstruct the modern paradigm from within, much like the *immanent critique* of the Frankfurt School applied to history. The latter proposes the best way to change a techno-capitalist society is from within, for example, by using modern technology (like the internet as a means of protest), rather than through a traditional Marxian-type revolution that acts from without. The paper applies this principle to psychology and therapy: “The deconstruction of texts as immanent critique goes hand in hand with critical innovations that introduce more relational and communitarian approaches to psychology research, teaching, supervision and therapy” (p.19).

An example of deconstruction as immanent critique is provided by therapists of a critical or postmodern persuasion (such as the author) who by necessity work *within* modern mental health institutions. They are required to engage with modern procedures and protocols for diagnosis and intervention, as well as work collaboratively with colleagues from a modern psychology or psychiatry background. This is exactly where a critical perspective is most needed, ‘in the belly of the beast’ so to speak; but it will only be heard from a stance of engagement with modernity rather than opposition. An example from therapy

practice illustrates how this critical and paramodern stance works in helping depressed and suicidal teenagers.

Commentary

This article (and the next) very much prefigure the argument in the thesis that deconstruction is an ethical gesture of hospitality that works *within* an institution like psychology or family therapy. This provides a theoretical template for developing an integrative family therapy model based on ethical practice, which is a mainstay of the thesis argument. This is applied to psychological practice in the treatment of childhood chronic illness in chapter 8 and adolescent depression in chapter 9.

11. Integrating family therapy in child and adolescent mental health practice: an ethic of hospitality (Larner, 2003)

This paper applies many of the ideas from the previous papers in a contemporary practice setting of child and adolescent mental health services (CAMHS). It proposes an evidence-based integrative practice model, where systemic family and narrative therapy are seen to complement and enrich modern individual problem-focused approaches, such as biological psychiatry and cognitive therapy. Based on a reading of Derrida's recent ethical writings, it suggests adopting an 'ethic of hospitality' towards different therapy discourses. This is illustrated by a detailed example of integrative family therapy with a depressed suicidal adolescent. Two independent commentators are then invited to address the politics of integration, one a senior child and adolescent

psychiatrist and state director of training and the other a senior clinician working in another CAMHS.

The paper begins with a discussion of some of the dilemmas of integrative practice for narrative and family therapists, particularly those working in a modern mental health system. This acknowledges: “A perspective that highlights relational or storied constructions of persons is very different to psychiatric and psychological discourses that internalise problems as aspects of individual biology or cognitive belief systems” (p.211).

Nonetheless the greater challenge for family therapists is not to reject ‘pathologizing’ discourses outright, as in the past history of their discipline, but to open a space for relational and narrative thinking *within* the modern system. This allows a wider conversation that puts family therapists in a position to encourage modern therapists to go beyond the use of psychiatric labels, medications and standardized or manualized treatments.

The description of deconstruction as immanent critique in the previous paper and the author’s idea of the paramodern are relevant here. However in this paper the ethical relation is put forward as a central theme for the first time, which prefigures the direction taken in the thesis writings. The paper suggests family therapists put systemic principles into practice and take the first step towards their non-systemic colleagues, by encouraging a spirit of dialogue and participation over and above theoretical or model differences. This respects and works within the traditions of psychology and mental health, *while* introducing

collaborative and relational approaches, which is a strategy that deconstructs modern practices of power.

The paper applies Derrida's notion of an 'ethic of hospitality', which explores the semantic link between the Greek word 'ethos' meaning 'home' and ethics as welcoming the stranger who needs assistance and taking in. The suggestion is to be at home with oneself, whether living in one's self or house, is to be in a relationship of hospitality towards the other. This was later brought home to me during a visit to Leuven, Belgium in 2007, where I gave a presentation on the topic of this paper. In the thirteenth century house I was hosted in, there was a plaque saying: *Si mon humble toit, a quelque beaute, plus belle encore, en est l'hospitalite*, which the owners translated as 'My hospitality is more important than my house'. This led me to think the house of a family therapist is made up of beliefs, ideas, experiences, prejudices, theories, knowledge, and techniques etc. Yet more than anything this house provides the means to enact hospitality and be systemic towards non-systemic strangers.

The paper suggests such an ethic of inclusion, integration and hospitality towards the stranger applies most of all for systemic family therapists. Thus a meaning of 'systemic' is to 'integrate' or to bring disparate parts into unity or conversation with each other. As the author comments: "In a spirit of hospitality family therapy brings one part of the whole in conversation or dialogue with the other. As family therapists, we feel the desire to engage, to be curious, reflective and interested in how the other speaks and makes meaning, to learn their

language while speaking our own. Family therapy *is* the wider understanding, the relational movement towards the other, whether at the level of the personal, the theoretical or the political. It opens up not shuts down borders” (p.212).

From this position of hospitality, the paper proposes a best practice guideline for all therapists working in CAMHS to consider: *To make optimum space for a systemic and narrative understanding contributes to evidence-based practice in a contemporary mental health service.* This highlights the crucial role of relational factors like the therapeutic relationship and personal narrative in an evidence-based therapy approach. According to an ethic of hospitality: “In the practice of therapy, all languages and approaches have their place and are needed” (p.213).

An ethic of hospitality is illustrated by a detailed case presentation of integrative family therapy with a suicidal teenage girl. This integrates individual and family therapy as well as approaches like narrative, art and cognitive therapy. It is suggested that individual therapy can be given a systemic context, first by seeing it as providing a therapeutic space or container for exploring a young person’s thoughts and feelings. Then as described in the NCFT approach of paper 5, with their permission elements of this narrative can be taken back to the family for a wider conversation (Larner, 1996, 2000).

The article concludes by charting ways in which family therapists can put an ethic of hospitality into practice in their CAMHS work context, such as valuing multiple frameworks and perspectives, co-therapy with non-systemic

colleagues, hosting educational events, and so on. Enacting this process of hospitality, the article provides space for a dialogic response from two senior clinicians.

Commentary

In many ways this paper is already an integral part of the thesis, as it provides a practice definition of an ethical stance in family therapy. An ethic of hospitality towards different languages of therapy is the basis for an integrative approach to family therapy developed in chapters 8 and 9 of the thesis. It is also used as a central bridging concept in chapter 2 and 3 for crossing the modern/postmodern theory divide. The phrase ‘ethic of hospitality’ derives from Derrida’s discussion of the work of Levinas. As such it provides inspiration and impetus for a more detailed exploration of the ethical relation in therapy in the thesis.

12. Family therapy and the politics of evidence (Larner, 2004a)

This final paper in the synopsis attempts to situate family therapy as a serious player in the politics of evidence-based practice. It was widely used in the literature to help justify the place of family therapy in a modern scientific world. Here *Sheila McNamee* (2004) a major social constructionist thinker described the paper as “an excellent discussion of the politics of evaluation” (p.242). Following the description of a critical-practitioner model (paper 9 above) it argues for a more flexible and broader interpretation of evidence for the

effectiveness of therapy: “The politics here concerns what is ‘evidence’, who defines it and the limitations of a scientist-practitioner model” (p.17).

This considers the problems of validity associated with randomised controlled research, as well as the crucial role of common factors in therapy, like the therapeutic relationship and a personal sense of hope in contributing to change. It also highlights the unique needs of a discipline like family therapy, where effectiveness research needs to do justice to its relational, language-based and client-centred approach. This is more concerned with the organic process of therapy, rather than the development of operationalised, step by step or manualized techniques for change.

The article describes the discipline of family therapy as being at the crossroads, where it needs to demonstrate a viable scientific evidence base if it is to remain a major therapy approach. It then shows how this challenge has been taken up by the profession, with significant steps already taken to show family therapy is effective across a wide range of clinical populations and problems. Nonetheless it is suggested more outcome research is required if it is to compete with cognitive-behavioural therapy and pharmacotherapy, which are widely accepted as the evidence-based treatments of choice in mental health services. At least this was the case until 2004 when this paper was published, for as I argue in chapter 9 of the thesis, an integrative therapy approach is currently considered a best practice option in treating problems like adolescent depression.

The paper goes on to examine what it calls the *politics* of evidence-based therapy especially the limitations of controlled research. As noted: “The politics here concerns whether clinically relevant and practice-based qualitative evidence is allowed” (p.20). It draws on a growing critique of the traditional scientist practitioner model from within the fields of medicine, clinical psychology and psychiatry. This provides the basis for a wider discussion about the kind of evidence that is relevant for family therapy practitioners.

The body of the article contains a comprehensive review of a broad range of evidence from the research literature showing that family therapy works. This is followed by a discussion of the politics of drawing up prescribed and (at this stage of research) premature lists of treatments, which dictate who is allowed to join an exclusive evidence-based club. The paper stresses the complexity of real life therapy, suggesting a notion like *best practice* as a more viable option for therapists. This draws on the notion of ‘clinical wisdom’ put forward in paper 9, where therapists choose treatments not according to an arbitrary evidence-based rule, but according to what they judge will be effective for the person and clinical situation at hand.

The paper suggests that family therapy is both a science *and* an art and proposes an integrative practice model that combines science with clinical or systemic wisdom from an ethical perspective: “In ethical best practice evidence-based techniques are applied *in response to* unique narratives of persons in political, cultural, community, spiritual and family contexts” (p.31). What is

proposed is a systemic-practitioner model for family therapy, where evidence-based practice is based on a relational or systemic approach to what works in therapy. This combines quantitative and qualitative evidence with local practice based experience, where randomised control research is applied in a relational and narrative context.

The article concludes with a description of a *systemic science* of family therapy. This acknowledges the need to play the evidence-based game or ‘politic’ at the same time as interrogating the dominant ideology of the scientist-practitioner model in arguing for a more diverse and practice-based evidence base. This puts family therapists in a better position to promulgate a relational, dialogic and narrative perspective in the wider world of therapy. This applies the deconstructive thinking in previous papers, in adopting a *paramodern* stance, which deconstructs the modern and scientific therapy paradigm from within its system.

Commentary

The notion of family therapy as a systemic science very much influences the thesis writings, particularly chapter 9 which proposes an integrative family therapy approach in the evidence-based treatment of adolescent depression. It is the basis for an ethical stance that straddles a modern scientific paradigm in therapy and social constructionist, systemic and narrative approaches, which informs the argument proffered in chapters 2, 3 and 4 of the thesis. The

argument is not to reject or go beyond a modern science of therapy but how to open it up to an ethical systemic and dialogic approach.

A major use of the author's article by Jacobs, Kissil, Scott, and Davey (2010) to argue for complementarity between evidence-based and postmodern approaches in family therapy has affirmed its continuing relevance for scholars in the field.

Summary of ideas from previous publications

In this section I summarize the main ideas from my previous publications, which are taken up and developed further in the thesis.

1. Literature and therapy

From the perspective of literature comes the deconstructive notion that modernism and postmodernism 'dance together', with both lenses required to do justice to the complexity of thought, life and therapy. This is a mainstay of the thesis argument for deconstructing therapy as an ethical practice.

2. Deconstruction

Until recently Derrida resisted any straightforward definition of deconstruction, describing it in terms like 'an experience of the impossible', which captures a sense of paradox, contradiction and aporia, and here he compared it to Bateson's notion of the 'double bind'. He often distanced himself from the populist iconoclastic version of deconstruction as simply taking modern meaning apart in a text. Unlike its perception by many postmodernists,

deconstruction does not attempt to overthrow and replace modern Enlightenment thought, but brings out other voices and writing in the text it has marginalized. More recently under the influence of Levinas, Derrida explicitly defines deconstruction as ethics or justice as expounded in the thesis. To deconstruct is to open up difference as an ethical gesture, which makes space for *many* languages and meanings in a text or narrative. It is this ethical definition of deconstruction that informs the thesis argument for the ethical relation in therapy.

3. *The paramodern*

This is the author's deconstructive idea that the modern and postmodern co-exist in practice despite the tension or contradiction in theory. This marks a distinction between deconstruction and a postmodern position and raises the possibility of deconstructing postmodernism. The paramodern therapist engages with the voices of a modern scientific psychology and family therapy *while* utilizing a postmodern relational, dialogic or social constructionist approach. Again this is another foundational idea for defining an ethics of therapy practice in the thesis.

4. *Change as miracle or other*

This is the notion that change is a deconstructive plurality or complexity, one which can be seen in terms of both science *and* miracle. While therapists can influence personal change by intervening in therapy, ultimately it is a narrative event that is *other* or transcends our understanding and falls outside the control

of a technology of therapy. In the thesis this links with the Levinasian philosophy of ‘ethics first’ or the primacy of the ethical relation over and above knowledge and technology.

5. *Deconstructing power*

To deconstruct power is to see it as both real *and* socially constructed, which straddles both a modern and postmodern understanding. The always present dilemma for therapists is how to empower others from a *position* of power?

This pre-empt the thesis argument that *how* therapists use power or ethics, is more relevant than epistemology or what they know or don’t know in relation to others.

6. *Narrative child family therapy*

This refers to the construction of a relational therapy space in which the child’s symbolic play as narrative is joined to the family story as social text in therapeutic conversation. This allows the integration of a psychoanalytic child therapy interview and family therapy as a hermeneutic, dialogic or narrative approach. This application of deconstruction constructs a dialogue between different (modern and postmodern) therapy approaches. This is further developed and illustrated in the thesis in terms of a model for integrative practice based on the ethical relation.

7. *Narrative as destiny*

This is the notion that personal identity is not merely postmodern, multiply constructed or arbitrary; rather the relational or socially constructed self

expresses an individual, self-reflecting, stable, centred and coherent identity across time. It also recalls the theme that therapeutic change often has its own narrative timing, that personal destiny is independent of therapeutic technology or intervention. The argument for a relational self that is nonetheless stable, coherent and centred informs the idea of the ethical self developed in the thesis. In terms of Derrida and Levinas, to be responsible for the other requires a strong rather than dispersed, weak or postmodern sense of personal identity.

8. *Knowing not to know*

This is a deconstructive stance in therapy that holds knowing *and* not-knowing together. It defines knowing in terms of not-knowing and vice versa, where what the therapist knows is not discarded but used in the session in a curious and not-knowing manner. It forms part of the therapist's inner conversation that helps to contribute to a dialogic or relational encounter. The author uses this concept to further explore the common ground between psychoanalysis and family therapy in the thesis, particularly in terms of constructing a narrative container for thinking to develop. The notion also describes an epistemological position that gives priority to an ethical stance, which recognizes the therapist's responsibility to *know* in order to effectively help others, but enacts this in a relational, dialogic and not-knowing way, which is respectful and hospitable towards the other.

9. *The critical practitioner model*

This critiques and extends the scientist practitioner model in therapy, arguing for a more broadly defined relational and qualitative evidence-base to judge what is going to be effective in therapy. This is based on a clinical wisdom that considers the relational and dialogic context of therapy and gives priority to the therapeutic relationship. It also acknowledges the contribution of common factors in all therapies, including personal attributes like hope and resourcefulness for change. In the thesis this informs the author's integrative therapy approach to problems like adolescent depression, which from an ethical position utilizes both scientific and social constructionist models of therapy. This links to the notion of *immanent critique*, which refers to deconstructing the modern paradigm from *within*. It introduces relational, narrative and communitarian approaches to theory, practice, research, teaching and supervision in modern psychology and therapy.

10. Ethic of hospitality

This defines a spirit of welcome, dialogue, inclusion, hospitality and participation of the other, which is put before epistemological, theory, model or paradigm differences. This integrates or brings into conversation disparate languages and approaches to therapy. As mentioned this notion already introduces the theme of the ethical relation in therapy as further developed in the thesis.

The above ideas from my previous publications lay a broad theoretical foundation for the thesis argument of deconstructing therapy in the ethical relation.

The structure of the thesis

Building on this body of work the thesis is conceived and written as a series of articles and book chapters for publication and structured as follows. Chapters 2-4 have a theoretical or philosophical emphasis laying the groundwork for an ethical understanding of deconstruction in therapy. The focus of Chapters 5-7 is the philosophy of Levinas and an explanation of the ethical relation in therapy. Chapters 8-9 are direct applications of ethical practice in integrative family therapy. Finally Chapter 10 is a summary of the main ideas of the thesis and discusses implications for practice and further research.

Below is a list of the main thesis chapters with their year of publication or current status highlighted in brackets. The chapters are presented as they appear in the published article, including footnotes except for those that occur in chapters one and ten, while spacing and headings have been standardized throughout the thesis.

List of thesis chapters as publications

Chapter 2: (**accepted for publication**). Deconstructing Theory: Towards an Ethical Therapy. *Theory and Psychology*.

Chapter 3: (**submission**). Ethical therapy as language of the other. Submitted to *Philosophy and Social Criticism*.

Chapter 4: (**2007**). The ethical play of irreverence in deconstruction and family therapy. *Human Systems, the Journal of Systemic Consultation & Management: Special Issue about Gianfranco Cecchin*, 16: 31–44.

Chapter 5: (**2004**). Levinas: Therapy as Discourse Ethics. Chapter 2 in Strong, T. and Pare, D. *Furthering Talk: Advances in the Discursive Therapies*. Kluwer Academic/Plenum Publishers: New York.

Chapter 6: (**2009**). Intersecting Bion and Levinas: The ethical relation as container in therapy. Book chapter in Flaskas, C. and Pocock, D. (Eds): *Systems and Psychoanalysis: Contemporary Integrations in Family Therapy*. London: Karnac.

Chapter 7: Larner, G. (**2008**). Exploring Levinas: the ethical self in family therapy. *The Journal of Family Therapy*, 30: 351–361.

Chapter 8: (**2009**). Integrative Family Therapy with Childhood Chronic Illness: An Ethics of Practice. *Australian and New Zealand Journal of Family Therapy*, 30: 51–65.

Chapter 9: (**2009**). Integrating family therapy in adolescent depression: an ethical stance. *Journal of Family Therapy*, 31:213-232.

In a thesis inspired by deconstruction, I have followed Derrida's example of writing "through small oblique essays" rather than in the fashion of a grand systemic treatise (Leitch, 2007, p.231). In order to meet requirements for

publication each chapter presents a self-contained argument for deconstructing therapy in the ethical relation, which is supported by a practice illustration. Publishing each chapter provided a rare opportunity for ongoing review and feedback from a range of scholars, assessors and fellow practitioners as the thesis was written. Several chapters were presented as papers at conferences allowing useful dialogue with colleagues. An overall challenge was to explicate complex philosophical ideas for a general audience and readership and to ground theory in the practice of therapy.

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Chapter 2: Deconstructing Theory: Towards an Ethical Therapy ¹

Abstract

Over the last two decades relational theorists and therapists have explored and consolidated discursive and relational approaches to therapy based on social constructionist, dialogic and narrative thinking. Meanwhile in mainstream psychology and psychiatry a modern scientific-realist epistemology prevails. While these two paradigms are diametrically opposed in theory, they are often required to be juxtaposed in practice especially for therapists working in mainstream mental health services. The paper addresses this theory and practice dilemma of how therapists can work in both therapy paradigms at once. This is illustrated by practice examples, including teaching relational therapy to psychologists trained as scientist practitioners and applying integrative family therapy with depressed and suicidal adolescents. Drawing on Derrida and Levinas the author then presents an ethical practice model called paramodern therapy. By deconstructing theory an ethical and integrative therapy is possible, one which engages with modern approaches while taking on board discursive, narrative or social constructionist metaphors.

¹ This chapter has been accepted for publication in *Theory and Psychology*.

Keywords: ethical, therapy, deconstruction, Derrida, Levinas.

Over the last two decades postmodern theorists and therapists, particularly in the field of family therapy, have explored and consolidated discursive and relational approaches to therapy based on social constructionist, dialogic and narrative thinking (e.g. McNamee and Gergen, 1992; Anderson, 1997; Rober, 2005; Bertrando, 2007; Wilson, 2007; White, 2007). In this paradigm persons are defined by the social, cultural, systemic, spiritual, communal and relational contexts in which they interact, speak and ‘live, move and have their being’, as St Paul once said. Or as Ken Gergen (2008) recently noted, the psychological self is not an independent, centred and rational individual existing in isolation from others, but a multi-voiced or relational being: “For the multi-being, there is no inside vs. outside; there is only continuous participation in relationship (p.338)”. In a relational therapy the therapist’s decentred or ‘not-knowing’ stance empowers clients to develop expertise and agency over their own life narrative. The therapist constructs a dialogic space for a conversation about change that is grounded in curiosity, meaning, language, story, context and the ethics of the therapeutic relationship.

Meanwhile in mainstream psychology and psychiatry a realist scientific epistemology and view of the self thrives and prevails. Psychological distress is defined in terms of discrete diagnostic problems like depression or anxiety, which are seen as deficits within the autonomous individual. These are

attributed to impaired ways of thinking, feeling and behaving, besides the contribution of genetics, biology and neuroscience. In modern disciplines like clinical psychology a scientist-practitioner model is applied, which treats individual psychopathology using evidence-based interventions like cognitive-behavioral therapy (CBT). Likewise in contemporary psychiatry a modern scientific framework is prevalent. This applies a normative classification system like DSM IV or ICD 10 to diagnose ‘mental and behavioral disorders’ in the individual. In biological psychiatry there is a growing body of scientific research linking psychiatric disorders like schizophrenia, depression and bipolar illness to genetics, biology and brain dysfunction. The main treatment approach is pharmacotherapy in combination with other evidence-based approaches like CBT or interpersonal therapy.

It is fair to say that a modern scientific and relational therapy paradigm is diametrically opposed in terms of theory. Yet for many relational therapists like the author who has worked in mainstream mental health services over three decades, they are often required to be juxtaposed in practice, despite the theory tension or dissonance. Here all practitioners, relational therapists included have a professional and ethical responsibility to use standard assessment protocols, apply effective treatments, manage psychiatric risk and work collaboratively in multidisciplinary teams with scientifically minded colleagues. Whether we like it or not and irrespective of whether it fits neatly into a particular theoretical or language paradigm, such integrative practice is an inescapable part of the

contemporary grammar of therapy. Perhaps this is where Wittgenstein's (1958) philosophical investigations into language have special currency. Rather than trying to account for or explain our use of a language, perhaps all we can do is note its practice and say: "*this language-game is played*" (p.167e).

Despite theory differences there are some signs of a shared language and practices between mainstream and relational therapies. For example, in clinical psychology there is a growing interest in integrative models like Dialectical Behavior Therapy (DBT) for borderline personality disorders (Rathus and Miller, 2002), mindfulness-based cognitive therapy for depression (Williams, Teasdale, Segal, and Kabat-Zinn, 2007) and acceptance and commitment therapy for anxiety (Harris, 2007). These developments in the scientist practitioner model as part of the 'third wave' after behaviorism and cognitive therapy incorporate a philosophy of mindfulness based on Buddhist meditation and ways of thinking. Here recent conferences have explored links between positive psychology, the neuroscience of happiness and spirituality based on the teaching of the Dalai Lama (Sydney, 2010). In mainstream psychology there has also been discussion of cultural and social justice issues affecting indigenous populations and research into the psychological effects of poverty (Pachana, 2010).

Within psychiatry there is also some voicing of political, social and cultural factors contributing to mental health issues. In Australia psychiatrists have highlighted the traumatic effects of long term detainment on asylum

seekers such as self harm, depression and suicide (Dudley, 2003). Recently Patrick McGorry a leading researcher in youth psychiatry, upon being elected 2010 Australian of the Year, described detention centers as ‘factories for creating mental illness’ and publicly called on the federal government to close them. These moves to redress personal psychological suffering at a political level and to introduce a culture of spirituality, social justice and mindfulness are perhaps encouraging examples of what Guilfoyle (2005) refers to as “*resistances* against culturally dominant discourses and practices” (p.101). They have much in common with the cultural and political focus of critical psychology and a relational and narrative therapy.

This paper explores the theory and practice dilemma of how it is possible for relational, systemic or social constructionist therapists to engage with a modern scientist-realist paradigm? It begins with a practitioner perspective outlining the challenges faced by relational and social constructionist therapists working in contemporary settings, which makes an integrative approach necessary. This is illustrated by practice examples, like teaching relational therapy to clinical psychologists trained as scientist practitioners and applying family therapy for depressed and suicidal adolescents. Then the paper draws on the writings of Derrida and Levinas to develop an ethical integrative practice model called *paramodern* therapy. In this way it works up from practice to theory in proposing an ethical therapy.

Deconstructing the scientific-relational divide in therapy

In many ways the scientific paradigm in therapy is a theoretical juggernaut oblivious of the relational perspective or postmodern critique familiar to readers of journals like *Theory and Psychology*. For example, in supervising psychology interns over three decades, the author has observed a virtual blackout of critical psychology or relational therapy ideas. Overall clinical psychology training is exclusively grounded in a strict interpretation of the scientist practitioner model, which remains the paradigm of choice for the profession and most psychologists in the field. This is the case despite serious critiques of the model like the following:

(1) There are methodological problems in transferring the results of so-called ‘evidence-based’ or randomized controlled trial studies, which are typically conducted in laboratory conditions with restricted populations, to the actual doing of therapy in real-life settings (Soldz and McCullough, 2000; Lerner, 2004).

(2) Meta-analytic research shows *common factors* across all therapies, like the quality of the therapeutic relationship, therapist variables like empathy and client attributes such as hope and expectation for change, contribute as much to outcome as the specific technique used (Duncan, Miller, Wampold and Hubble, 2010; Sprenkle and Blow, 2004). The significant role of relational context in therapeutic change was recently corroborated by medical research into the placebo effect, which demonstrated the health of persons can improve in

response to how treatments are delivered (Finniss, Kaptchuk, Miller and Benedetti, 2010).

(3) Where presenting problems are complex, multiple and contextual in nature, as for children and adolescents, therapists are often required to be creative, intuitive and combine different models and treatments. This cultivates the art of therapy as much as its science (Larner, 2001).

(4). The focus of much evidence-based research is outcome or ‘what works’, while the important question of therapeutic process or why and how particular treatments work is neglected.

In other words the evidence for a strict scientist practitioner model in therapy is itself in question (Goodman, 2003). Or at least one based exclusively on randomized control research, which excludes other ways of measuring therapy effectiveness, like qualitative measures, discourse analysis and practice-based research (Campbell, 2002; Stratton, 2001). What is often put forward as ‘evidence-based’ treatment can say more about the politics of therapy than its science, like the kind of empirical research funded and competition between professions for scarce mental health resources. An ideology of scientism prevails where any critique of the scientist practitioner model by relational therapists is largely sidelined (Larner, 2004). On the positive side key figures in the child and adolescent therapy field such as Alan Kazdin (2003) have voiced the limitations of a randomized control research paradigm. There is also increasing recognition of the effectiveness of relational and family therapy for a

range of psychological issues (Carr, 2009a, 2009b), particularly for intractable problems like eating disorders (Rhodes, 2003).

While some mainstream practitioners are more interested in what relational therapies have to offer, the social constructionist, dialogic and narrative theory that has informed these approaches in recent years is largely sidelined. How can, should or do relational therapists respond to this theory dichotomy? Understandably many batten down to work exclusively within their preferred framework and continue to urge a paradigm shift to a narrative, social constructionist or relational metaphor in therapy. This certainly appears to be the case for narrative therapists like Michael White (1997, 2007) when he draws on poststructuralist philosophers like Foucault to critique the ‘problem-saturated’, ‘objectifying’ and ‘totalizing’ approaches of modern therapy. These pathologizing practices are deconstructed and replaced by more benign narrative approaches like externalizing conversations. These separate the person from the problem and enhance the client’s agency to resist dominant cultural and psychological discourses that influence their personal identity. As White (2007) notes: “Externalising conversations in which the problem becomes the problem, not the person, can be considered counter-practices to those that objectify people’s identities (p.26)”. In this regard Guilfoyle (2005) sees narrative therapy as one example of a ‘therapy of resistance’, this privileges client over professional knowledge and mobilizes political action against cultural discourses of power.

Likewise the language-systems or collaborative therapy approach of Harlene Anderson (1997) offers “profound alternatives” to the scientific realist position. This draws on social constructionist thinkers like Gergen and Shotter and the dialogic philosophy of Bakhtin and Voloshinov to describe therapy as a ‘philosophical stance’ or *way of being* with others based on relationships, meaning, conversation, dialogue and story. As Anderson (1997) says: “A therapist brings expertise in the area of process: a therapist is the expert in engaging and participating with a client in a dialogical process of first-person story-telling (p.95)”. From a stance of ‘not-knowing’ and curiosity, the therapist asks questions to elicit personal meaning and engage the client as an expert in the change process.

A social constructionist approach shares with narrative therapy a relational and storied vision of the world, self and knowledge, which is counterpoised to a modern scientific paradigm in psychology and psychiatry.

A case for dialogue between theory paradigms

Nonetheless a dogmatic theory position that dismisses outright the modern scientific paradigm and urges therapists to ‘move on’ to a relational or narrative framework is counterproductive to the cause in several ways. First it closes down dialogue with mainstream colleagues, including an opportunity to argue the benefits of a relational or dialogic approach. This is relevant when standard interventions like CBT prove ineffective or not enough, as is often the case for complex therapy presentations. Where relational therapists can engage in a

meaningful dialogue and exchange with scientific therapists, the latter are more likely to reciprocate, although this is by no means guaranteed (Larner, 2003).

Later I will argue such hospitality towards different theory frameworks is part of an ethical stance in therapy.

Second it risks perpetuating the same divisive politics and hegemony of a theory position that marginalizes, excludes and replaces alternative points of view, which is precisely what relational therapists critique about modern therapy. Here the word ‘modern’ derives from the Latin *modo* to mean what has been thought before is displaced by the present or ‘just now’. However this is the very move *post*-modern or relational therapy makes when it *opposes* the old scientific paradigm and seeks to replace it with an entirely new relational or social constructionist voice.

The relation between modern and postmodern thinking is rather more complex and characterized by paradox, contradiction or what Derrida calls *aporia* (Larner, 1994). Even for Lyotard (1979) the postmodernist per exemplar, postmodernism cannot simply be defined in terms of an opposition to modernism, or as he says: “A work can become modern only if it is first postmodern. Postmodernism thus understood is not modernism at its end but in the nascent state, and this state is constant (p.79)”. In other words the ‘incredulity towards meta-narratives’ that famously defines the postmodern is present at the birth of each new paradigm, the modern included. If to be postmodern is to question foundations, shed power and hierarchy and give voice

to dialogue, difference and multiplicity, then to be consistent a modern perspective somehow needs to be included within the conversation. Perhaps Gergen (1999) points the way forward here, when tired of the ‘science wars’ in psychology, he refers to reconfiguring rather than abandoning the modern tradition: “Should we simply cast away the vast domain of empirical literature-journals, handbooks, monographs treating all aspects of human action? Not at all (p. 93)”.

Third there is increasing pressure on all therapists to think within a scientific paradigm and use evidence-based interventions from service directors, professional accreditation and registration bodies, training institutions, government employers and medical insurance. For example, as a senior clinical psychologist in an adolescent mental health service, the author has a professional and ethical responsibility to help teenagers and their families in the most effective way possible. In this practice context there is an unquestionable obligation to take on board the mental health language of the service and the profession; to put it bluntly it is written into the job contract. This includes utilizing assessment and treatment procedures widely accepted as best practice for a range of clinical presentations. And here modern therapy approaches like CBT for anxiety or closely supervised medication for severely depressed adolescents can be helpful interventions. This is not to mention the fascinating insights of recent neuroscience that support an ethical and relational perspective of the human (Post, 2005).

An integrative practice approach

In these terms the future theory challenge for relational therapy may be less concerned with how to replace a modern scientific paradigm and more with asking how it is possible for a social constructionist, narrative and dialogic approach to sit with or even *within* it! This addresses the pragmatic question of how relational therapists can survive and function as professionals in the world of modern therapy. It also provides an opportunity for therapy practitioners to step beyond the theory wars of the last two decades to map out an alternative third way. This would need to acknowledge both a scientific-realist *and* a social constructionist account of self and knowledge, despite the theory inconsistency. This is no doubt a provocative position to take, especially given the range of theoretical debates in journals like this one (e.g. Mackay, 2003).

However as I will argue this is an ethical question of how the different languages of therapy can co-exist, have dialogue with and enrich each other. Here ethics or *how* we know in relation to others, including our modernist colleagues, takes precedence over epistemological or theory claims. What is deconstructed is not the theory position of *others* but one's own, or the very process of polarisation whereby one paradigm overcomes and replaces another. In a similar way Guilfoyle (2005) argues an ethical priority for therapists to clarify where they stand in relation to the dominant cultural and psychological discourses of the day, irrespective of their theory persuasion. As discussed above, relational and narrative therapists would no doubt applaud the political

and ethical positioning of mainstream Australian psychiatrists on behalf of marginalized ‘boat people’.

In this section I provide illustrations of ethical and integrative practice in the context of teaching and doing therapy. Recently the author ran a 10 week introductory family therapy training program for clinical psychologists in the workplace. Trained as scientist practitioners these therapists typically adopted an expert role, which involved psychological case formulation and applying an appropriate evidence-based intervention. As family therapy trainees they were invited to temporarily put aside their usual scientific paradigm and take a first step towards a relational understanding. This began with a *Systemic Mindfulness Exercise* along the following lines: “Close your eyes breathe deeply and relax etc. For the time being I want you to put aside the individual and scientific therapy frameworks you are used to thinking in... I now invite you to step into a systemic world where what matters is relationships, dialogue, story and conversation. Raise your little finger if you are willing or able to do this”.

Over subsequent weeks various elements of a systemic family therapy and social constructionist approach were introduced and demonstrated using a reflecting team behind the one way screen. This included being able to work with the relational context, stepping back from being a scientific expert, taking a not-knowing and curious stance, giving priority to the client’s story and meaning, being collaborative in the therapeutic relationship, and so on. Towards the end of the program the students were challenged to describe psychological

problems in terms of relational meaning, story and context *as well as* using their preferred scientific framework like cognitive-behavioural therapy. To this end the group discussed how evidence-based techniques can be applied in a flexible, creative, person-centred and collaborative way, in concert with a relational therapy approach.

Now what made it possible for these therapists to take on board relational thinking was their willingness to put aside a strict scientist practitioner model and participate in a dialogue about another point of view. However this required the author first demonstrate a similar flexibility about theory in being curious about what a scientific psychological therapy had to offer. Cecchin, Lane and Ray (1993) describe this positioning as an *irreverent* stance towards theory, where therapists resist “becoming a true believer in any approach or theory...that limits their practice options (p.129)”. From this perspective the theory challenge is how to be respectful and hospitable towards the modern scientific knowledge that is available to the profession *while* adopting a narrative, dialogic and relational focus. This is a both/and positioning that does not abandon or *post* a modern scientific therapy, but attempts to widen its landscape or horizon.

In many ways such a path towards integrative practice is already a feature of contemporary family therapy (Vetere and Dallos, 2003). Thus the discipline continues to construct a scientific evidence-base *at the same time* as it engages creatively with systemic, social constructionist, dialogic and narrative

approaches (Carr, 2009a; Stratton, 2001). This is a double movement that has been variously called theory flexibility (Flaskas, 2002), promiscuity (McNamee, 2004), irreverence (Cecchin et al 1993) or systemic science (Larner, 2004). In a relational and dialogic therapy we see modern and postmodern approaches mixed freely according to the requirements of practice. For example, in *The Performance of Practice* Wilson (2007) uses modern structural family therapy interventions *within* a dialogical framework for therapy. Likewise Bertrando (2007) in *The Dialogical Therapist* practices systemic family therapy from a dual modern/ postmodern position without trying to resolve the tension. The *open dialogue* approach to serious psychiatric problems like schizophrenia utilizes a scientific outcome research model to evaluate effectiveness and incorporates recent developments in neurobiology (Seikkula and Trimble, 2005). This intersection is also suggested by Rober's (2005) description of the inner conversation between the therapist's experiencing (not knowing) and professional (knowing) self.

The music of therapy

The idea of ethical integrative practice can be described using a musical analogy. At the 2009 *Sydney Festival* I had the privilege to hear Misha Alperin and Mikhail Rudy in a joint piano concert called *Double Dream*. Alperin is a progressive jazz pianist with several ECM label recordings on the cutting edge of European jazz improvisation. Rudy is a renowned and popular Russian concert pianist and performer of classical music and contemporary

compositions. The concert was a dialogue between these two musicians on a double piano, where facing each other they took turns to perform a short piece of music, which the other then responded to by composing and improvising on the spot. In this way two disparate musical genres were deconstructed and crystallized into one, taking classical music into an improvisational jazz space and vice-versa.

This is not unlike a play-off between a classical modern scientific therapy and an improvised relational and dialogic approach grounded in the interactive and conversational moment of the now. As for the musicians, the challenge is how therapists coming from different traditions or frameworks *in practice* can play together and here the boundary that separates them may be more fluid than theory would suggest. The following practice illustration describes the music of integrative practice in more detail.

Practice Illustrationⁱ

Belinda (B) 15 years presented with severe clinical depression, frequent self harm (cutting) and serious suicidal risk involving drug overdoses and attempted hangings requiring several hospitalizations. The main triggers were an abuse of alcohol, conflict with her parents and social exclusion by peers. However Belinda had experienced major attachment ruptures from an early age, with her mother suffering depression and alcohol abuse and there was a prolonged history of intense conflict between the parents. In the psychology research

literature such traumatic life events are significant risk factors for adolescent depression and suicidality (Larner, 2009a).

Belinda required regular psychiatric assessment and antidepressant medication, which was monitored by the team psychiatrist, as well as weekly individual therapy sessions with a clinical psychologist over eighteen months. The latter involved cognitive therapy, learning distress tolerance and mindfulness skills (DBT) and the expressive use of music, art and writing in the context of an ongoing therapeutic relationship. Various team members participated in ongoing crisis assessments and there were ongoing consultations with child protection workers, school counselors and hospital staff, including several interagency care plan meetings involving the family.

Despite all this therapeutic and service input Belinda's depression and suicidal risk remained at a critical level. A bleak, unloving and unstable family atmosphere contributed to her frequent slide into increasing depression, self harm and despair, which elevated the anxiety levels of the treating systems involved. After yet another serious suicide attempt, a family therapy consultant suggested a structural family therapy intervention, to help the parents manage their conflict and contain Belinda's high level of risk. Unfortunately after six joint parental sessions their hostility actually increased! After further conversations between Belinda's therapist, the team and the consultant, the following systemic pattern was identified: the angrier the mother became with the father the less emotionally available she became for Belinda, who continued

to slip in and out of crisis as therapists and services became more anxious about her escalating distress. As the mother later explained she was always afraid Belinda would ‘push her over the edge’, especially given conflict with her ex-husband and her recent recovery from depression.

After further team consultation, the author invited the mother to individual therapy to support her parenting role and address a significant attachment breach with Belinda dating from her infancy. Such relational repair was a crucial step for constructing a holding environment for Belinda’s risk behavior, as suggested by evidence-based research showing the benefits of attachment-focused family therapy for adolescent depression (Diamond, Siqueland and Diamond, 2003). It could also be seen as a structural family therapy intervention, which encouraged the mother to move away from conflict with her ex-husband to focus on emotional care of herself and her daughter. Over several sessions the mother was invited to recount her earliest memories and stories about Belinda and share them with her. This attachment exercise attempted to restory their shared life experience as a coherent life narrative.

After several months signs of a stronger attachment relationship emerged and the author asked the mother the following systemic question: “Now you are less caught up in anger and conflict with your ex-husband, what difference has it made for your relationship with Belinda?” Her reply was apt: “I’m more relaxed. Belinda picks up on how I am and can approach me when she needs to. The interaction has improved and I’m not so worried about her self-harming”.

At this stage the author arranged family therapy sessions involving Belinda, her mother and a younger sibling, which took place along systemic and social constructionist lines with a colleague over several months. This continued to build a secure base in the family for containing Belinda's depression thus offering hope in the face of hopelessness (Flaskas, 2007).

Follow-up two years later revealed Belinda had completely recovered from her depression with a complete absence of self-harm. She had ceased all medications, started her own business and the mother-daughter relationship had significantly improved with reduced conflict between the parents. Both reported what they found most helpful were the various therapists and services working together in harmony.

This practice example illustrates therapy is a complex process that often requires multiple layers of work where therapists draw upon a range of paradigms and approaches at once. This accords with the evidence-based literature for treating adolescent depression, which suggests an integrative therapy approach that combines psychiatric risk assessment, crisis intervention, individual cognitive-behavioural therapy, medication where needed and systemic family therapy is a best practice approach to treatment (Larner, 2009a). As in the *double dream* music analogy, an essential requirement is a respectful and creative interplay between different approaches and traditions in therapy. In dialogic terms Wilson (2007) calls this creative approach to therapy 'the performance of practice'.

Elsewhere the author has described integrative practice in terms of an *ethic of hospitality* towards different languages and theory frameworks in family therapy (Larner, 2003; 2009a, 2009b). A useful metaphor here is the *matryoshka* or Russian dolls, where one therapy approach or language can be seen as nesting or fitting inside another. In the practice illustration, modern evidence-based interventions were wrapped within an overall relational, narrative, collaborative and dialogic stance in therapy. In Belinda's individual therapy the use of techniques like CBT and DBT sat inside artistic and writing expression in the context of an ongoing therapeutic relationship. In turn this was contained by relational therapy focusing on structural and attachment repair. A larger therapeutic doll was formed by a modern psychiatric framework of risk management, which involved crisis assessments, hospitalizations and pharmacotherapy. In all of this ongoing dialogue involving Belinda and her family, the therapists, the team, the consultant and other helping systems formed a crucial part of the therapeutic wrapping paper that helped to contain the risk of depression and self harm.

A paramodern stance in therapy

Drawing on Derrida's writings, the author has called this integration of modern scientific and postmodern relational frameworks a *paramodern* stance, where the prefix '*para*' means both 'beside' (e.g. paramedical) *and* 'beyond' (e.g. paranormal) at the same time (Larner, 1994). This neologism is used to describe the practice positioning of the contemporary therapist, who has one foot in a

modern psychological science *while* stepping forward to a social constructionist, narrative or relational approach. It reflects Derrida's (1995) caution that we cannot simply step outside modern philosophy and language into a post-modern or dialogical framework: "Overcoming is not the end. One doesn't jump out of metaphysics one fine day, in order to go over to something else (p.48)". Rather deconstruction works from the inside out, it engages with a modern text or discourse using its language and thinking to trace an alternative or marginalized story nesting within it.

In *The Ethics of Deconstruction* Simon Critchley (2002) explains a deconstructive stance as follows: "The deconstructor is like a tight-rope walker who risks 'ceaselessly falling back inside that which he deconstructs'" (p.29). This is captured in the above practice examples where the contemporary therapist likewise walks a deconstructive tightrope. This is a stance that balances modern therapy and its discourses of power and knowledge on the one hand with a relational and narrative understanding on the other. These different forms of knowing and not knowing are held together as a *knowing not to know* (Larner, 2000). Or if you like the two cultures of a relational-humanistic and scientific sensibility are brought into conversation with each other (Snow, 1998). Here persons are seen as relational and dialogical beings embedded in culture, context and language, or as Gergen (2008) eloquently says: "The person is essentially constituted, then, by a multiplicity of relationships" (p.338). At the same time they can be described in modern scientific terms as biological or

cognitive- mindful creatures. What is at stake here is the flexibility and freedom to think human being in terms of many different languages or paradigms at once.

From this integrative perspective relational therapists need not discard their modern professional knowledge or prior experience and training, as if that were desirable or possible. The dialogic therapist Harlene Anderson (2005) says as much: “A not-knowing position does not mean the therapist does not know anything or that the therapist throws away or does not use what she or he already knows. It does not mean the therapist just sits back and does nothing or cannot offer an opinion...” (p.503). Rather what matters is ethics or what therapists *do* with their knowing, that is, *how* they use it in relation to others? As in the case of Belinda, modern therapy interventions like biological psychiatry or CBT-mindfulness can be integrated within a relational and narrative therapy approach. Where research informs us about effective methods for helping adolescent depression like CBT and family therapy, psycho-education, sleep hygiene, exercise and so on (Larner, 2009), these approaches can be applied in a relational and collaborative way that engages the narrative voice of the other.

A paramodern or practice-based stance in therapy gives equal priority to science *and* relational or dialogic encounter with the other. It is integrative in the sense of drawing on and speaking *many* therapeutic languages, approaches and frameworks at once. Rather than proposing another meta-theory or

paradigm to replace what has come before, the priority is *what works* for the person or the ethics of practice. This recognizes all practitioners have a responsibility to help others in the best way possible, by accessing a diversity of discourses, approaches and practices in the profession. Therapists are less caught up in endless debates about theory, epistemology or *what* model, technique or approach is true or correct and more concerned with the ethical relation to the other. As Guilfoyle (2005) argues their ethical priority is to resist modern discourses of power, which transcends different theory positions and ways of knowing, whether social constructionist, narrative etc.

In a paramodern stance, the knowledge and technology of modern psychology and therapy is not rejected, but utilized in a way that puts the relation to the other *first*. The diverse languages and practices that form the heritage or foundation of the discipline remain available to the therapist. This meets an ethical requirement for therapists to alleviate psychological suffering in the most effective or helpful way possible. It allows therapists working within a relational or social constructionist framework to access a range of approaches or knowledge as needed. This might include developments in neuroscience, biological psychiatry, mindfulness-based cognitive therapy, positive psychology, dialectical behaviour therapy, or any other technique or approach that helps to alleviate psychological problems.

The author now draws upon the ethical writings of Derrida and his colleague Emmanuel Levinas to further describe an ethics of practice in therapy.

This argues from an ethical perspective that relational therapists need not abandon modern scientific knowledge so much as recognize its limits.

An ethics of practice in therapy

Commentators generally agree that Derrida's later writings particularly post 1990's demonstrated a sharper political and ethical turn to focus on ideas of responsibility, hospitality, ethics and justice (Royle, 2003; Smith, 2005; Leitch, 2007; Wolfreys, 2007). As Critchley (2008) recently observed, "motivating Derrida's praxis of reading and thinking was an ethical demand" (p.8). Or as Derrida (1994, 1995, 1999) has himself emphatically stated on a number of occasions, deconstruction *is* hospitality, ethics or justice etc. While Derrida maintains his work has always had a political and ethical focus, such a clear and authoritative definition was influenced by a close reading of the ethical philosophy of his colleague Emmanuel Levinas (Derrida, 1999, 2000).

A central idea for Levinas (1969) is ethical subjectivity, which he describes in the opening pages of *Totality and Infinity* as follows: "This book will present subjectivity as welcoming the Other, as hospitality; in it the idea of infinity is consummated" (p.27). The self, personhood or subjectivity is formed through our responsiveness to others; or as Derrida (1999) quoting Levinas says: "The word *I* means *here I am*, answering for everything and for everyone" (p.55). To welcome and be hospitable towards another person, especially in response to their face is a crucial aspect of what it is to be a human being. Though for Levinas the face is not merely a physical visage, but everything

about another person that is *more than* we can think or describe using thought or language: “The face is present in its refusal to be contained. In this sense it cannot be comprehended, that is, encompassed” (Levinas, 1969, p.194). In this way the other expresses or consummates the idea of infinity.

To reduce the lived experience of another person to categories of psychological understanding is a totalizing act of language that eradicates their uniqueness and difference. To bring the humanity of the other under a finite concept is to categorize it as this *or* that using the rule of logic or reason. This is what Derrida calls the threat of the spoken word or *logos* in a discourse, “the brutality in a discussion, in an argumentation, the dogmatic fiat...that which does not let the other be what he is, does not leave room for the other” (Derrida and Ferraris, 2001, p.91-2). By contrast, in an ethical encounter the person “overflows absolutely every idea I can have of him” (Levinas, 1969, p.87). The other disturbs the hubris of my knowledge as a closed system or totality of thinking, opening it up to difference and the infinite.

Simply put, for Levinas in the presence of another person we are required not to *know* but to *respond*. This is a being *for* the other that is pre-conscious, pre-discursive and occurs before language at a sensory, affective and physical level. As Levinas (2004) says in *Otherwise Than Being*: “The subjectivity of a subject is vulnerability, exposure to affection, sensibility...an exposure to expressing, and thus to saying, thus to giving” (p.50). From this radical ethical perspective the very subjective ‘I’ of consciousness is constituted by a gesture

of hospitality towards the other. Here the Cartesian cogito, which defines the self as a thinking, rational or knowing being transforms into the ethical equation: *You therefore I* (Larner, 2008).

Here Levinas describes the ethical relation as asymmetrical or going *one way*, where I take responsibility *for* the other without expecting or seeking a similar response in kind. The philosopher Rosalyn Diprose (2002) calls it *corporeal generosity*, which is “not reducible to an economy of exchange between sovereign individuals. Rather, it is an openness to others that not only precedes and establishes communal relations but constitutes the self as open to otherness” (p.4). This is distinct from a ‘conditional’ social exchange where persons or even ‘selfish genes’ can be cooperative on the basis of mutual benefit and self-interest (Dawkins, 1976). The idea of altruism, empathy or hospitality is a fundamental aspect of being human that finds support in recent research in biology and neuroscience (Post, 2005; Fehr and Gächter, 2002). Here a recent study using magnetic resonance imaging demonstrated that generosity towards others activates the pleasure centre in the brain (Tricomi et. al., 2010). The importance of empathy in evolutionary biology has been linked by Ramachandran (2000) to the discovery of ‘mirror neurones’, which he notes “will do for psychology what DNA did for biology” (p.1).

Following Levinas the social constructionist thinker Edward Sampson (2003) refers to the ethical relation as ‘unconditional kindness to strangers’ and proposes it become the foundation for a truly relational psychology. Others have

been inspired by Levinas to explore an ethical psychology and therapy (Gant and Williams, 2002; Kunz, 1998; Larner, 2004b). For example, Walsh (2005) advocates we step *beyond therapy* as the mere application of theoretical knowledge and technical interventions and see it as an ethical encounter between persons. Likewise the family therapist Tom Andersen (2001) argues the ethical priority is not knowledge, but connecting and collaborating with others through language and conversation. He exhorts therapists to follow Levinas in putting *ethics before ontology*, where relationships and dialogue take precedence over the philosophical study of knowledge, Being or *what is* in the world. In a similar vein after Levinas, the author describes ethical therapy as “an experience of the mysterious and impossible; it is reaching out to the other in the imagination” (Larner, 2009c, p.217).

Ethical Knowing

As described here an *ethics-first* philosophy fits well with a social constructionist or relational paradigm of therapy. Nonetheless there is a crucial difference in how they account for ethical knowing. Thus for Derrida and Levinas the ethical relation requires the use of modern thinking and concepts, as without them we could not think and act responsibly. Derrida (1997b) puts it like this: “For yet again, one *must* certainly *know*, one *must know it*, knowledge is necessary if one is to assume responsibility...” (p.69). Here Derrida (1999) presents his understanding of Levinas and hospitality as follows. The ethical relation involves a face to face encounter between persons, however to take a

position on social justice requires the use of judgment and reason that betrays this relationship: “I have to compare, I have to use concepts, I have to refer to resemblance, everything which implies ontology in the Greek sense and is divorced from ethics in the Levinasian sense. So I have to go back to Greek philosophy, in order to be just (Derrida, 1999, p.68)”.

At the same time as Levinas (1984) influenced by Derrida concedes, to *not* use modern knowledge and technology in the service of others is itself unethical,: “This is the great paradox of human existence: we must use the ontological for the sake of the other, to ensure the survival of the other we must resort to the technical-political systems of means and ends... We have no option but to employ the language and concepts of Greek philosophy even in our attempts to go beyond them” (p.64). Here Levinas (2004) makes a fundamental distinction between the thematic or objective content of discourse as what is *Said* and the relational or ethical context in which speaking takes place, which he calls the *Saying*. The face to face relational encounter of the *Saying* is a gesture of welcoming, hospitality and responsibility, where I refrain from imposing my language and way of thinking on others. Nonetheless this ethical relation is what provides the interpersonal context for knowledge (as what is *Said*) to be communicated: “*Saying* states and thematizes the said, but signifies it to the other, a neighbor...in proximity...conceived as a responsibility for the other” (Levinas, 2004, p.46).

In other words knowledge and ethics go together, or as Derrida suggests, to be ethical and act responsibly one needs to *know*. To paraphrase the Enlightenment philosopher Immanuel Kant, knowledge without ethics is hubris, while ethics without knowledge is blind. For Levinas the relational encounter of the Saying does not reject knowledge, but provides a vehicle for its expression in an ethical context. Knowledge is not discarded but exposed to scrutiny as we become aware of its effects on others. As Critchley (2002) notes for both Derrida and Levinas: “Ethics is not the simple overcoming or abandonment of ontology, but rather the deconstruction of the latter’s limits and its comprehensive claims to mastery” (p.8). Thus what Levinas (1969) contests is not Western knowledge itself, but its claims to an impersonal, transcendent and objective status that is potentially violent towards the other. He sees knowing as a critical or reflexive activity that always “puts itself into question” (p. 82) and “leads back to the relation with the Other, that is, to justice” (p. 89).

While there is knowledge, the response to the other as ethics and justice comes first. As for Derrida to deconstruct *is* to be ethical, hospitable and welcoming towards the other as a political gesture asking: how does my speaking or knowing silence the other’s voice or knowing? Following Levinas, Derrida (1994) deconstructs for the sake of justice, which he calls ‘irreducible’ or ‘undeconstructable’. Here deconstruction *is* justice, in so far as it recognizes the other as singular, different or wholly other. Or as Derrida (1997) puts it: “That is what gives deconstruction its movement, that is, constantly to suspect,

to criticize the given determinations of culture, of institutions, of legal systems, not in order to destroy them or simply to cancel them, but to be just with justice, to respect this relation to the other as justice” (p.18). This is why Derrida has often said he deconstructs a modern discourse or text not to destroy or replace it, but from a stance of love and respect: “Now, there is no deconstruction that does not start with the attempt to respect a text or discourse. That said, it is certainly not a question of destroying the text or belief or thought of the other, nor of belittling it in any way” (Derrida and Ferraris, 2001, p.63). Again in challenging the hegemony of a discourse or system of knowledge, deconstruction begins with “love...by paying homage to that which, to those whom, it “takes on”” (Derrida and Roudinesco, 2004, p.5).

In this sense deconstruction is not a technique or method we apply *to* a text or paradigm from the outside in order to ‘take it apart’, as it is commonly understood. Rather it works from the inside, destabilizing *while* it stabilizes, disturbing the foundations of a text, discourse or institution from within, without wanting to go *beyond* (Derrida, 1990). It disrupts the hierarchical structure of theory by demonstrating the impossibility of closure:

“Deconstruction resists theory then because it demonstrates the impossibility of closure, of the closure of an ensemble or totality on an organized network of theorems, laws, rules, methods “(Derrida, 1990, p.86). The ethical movement of deconstruction opens up theory to difference and the other, bringing out a counter-story that is already there.

In this sense deconstruction is less something we do *to* others and more what we demand for ourselves. As justice, hospitality and the ethical, it addresses how *we* speak, think and apply theory and knowledge in relation to others. It is a revolution that works from within, introducing a spirit of justice as open and self-reflexive enquiry. This recognizes all language, concepts and theories, whether they are part of a scientific or relational therapy, have the potential to assimilate others to our way of thinking. Following Derrida we become ethical by taking the road of *less* power and violence towards others, not by becoming knowledge free or power-less. This recognizes the paradoxes of power, where to deconstruct it requires taking a *powerful* position on ethics and justice (Larner, 1995; Guilfoyle, 2005).

In this way the ethical writings of Derrida and Levinas have significant implications for the theory and practice of therapy. As therapists we are obliged to relieve human psychological suffering using the best means and knowledge at our disposal. This doesn't preclude modern scientific knowledge but requires it! Here we do not go *beyond* a scientific therapy so much as ethically work within it. Instead of seeing a relational paradigm as opposed to a scientific therapy, the idea of the paramodern suggests a way for therapists to radically work within both at the same time. Rather than relational therapists abandoning a scientist practitioner model they can point to something else required in the complex equation of therapy, namely language, dialogue, story, context and relationship.

Conclusion

This paper has addressed a major theory divide between scientific and relational paradigms in therapy. By deconstructing theory in the ethics of practice it has illustrated how therapists can draw on both paradigms or discourses at once. For relational therapists working in modern psychology and psychiatry contexts this meets an increasing obligation to adopt an evidence-based or scientist-practitioner model. Following Derrida and Levinas all therapists whatever their theoretical persuasion have an ethical responsibility to relieve psychological distress in the most effective way possible. From this perspective an ethics of practice in therapy needn't exclude a scientific paradigm but requires it. The future theory challenge is how to take relational approaches to mainstream therapists and show how they can be utilized without relinquishing a modern scientific therapy approach?

To this end this paper has proposed a *paramodern* or ethical integrative practice model, one which is both modern *and* postmodern or scientific *and* relational at the same time. Where the ethical relation is put *first* before theory or epistemology the division between these paradigms can be deconstructed. Derrida's (1999) notion of an ethic of hospitality provides a useful maxim: If I am open and hospitable towards my colleague's perspective and way of working they are more likely to do likewise and engage with mine. Where an ethics of practice takes precedence over epistemological or theory claims, a more flexible approach to different knowledge positions is possible.

Practitioners can respect and draw upon scientific approaches in therapy *while* working within a relational, narrative or social constructionist metaphor.

Ethical knowing in therapy welcomes the other into dialogue and relationship; it gives priority to the others meaning and way of speaking without giving up one's own. It is an invitation to the other to speak *first* in a gesture of hospitality, which is: "tending toward the other, attentive intention, intentional attention, yes to the other. Intentionality, attention to speech, welcome to the face, hospitality-all these are the same..." (Derrida, 1999, p.22-3). The ethical is an orienting towards the other as they speak; it is a gesture of open enquiry into the meaning of their discourse. The primary orientation is *to* the other and to be *with* the other, face to face, while maintaining separateness.

However knowledge, reason and technology are still there! Following Levinas (1984) this meets an ethical obligation to make available the knowledge and technology required to assist human suffering. If a person presents with a particular problem like anxiety, depression or schizophrenia, the responsibility of the therapist is to offer what is most likely to be helpful. From an ethical stance *how* therapists use knowledge in relation to others is more relevant than whether they speak a particular theory or language of therapy.

This I believe is the import of the ethical writings of Derrida and Levinas for psychology and therapy. It is ethics before knowledge, but to be ethical still requires us to know. In deconstructing theory what remains is the ethics of practice. Or as Derrida (2007) said in the final interview before his death,

deconstruction concerns an *ethos* of writing and thinking that has allowed him to finally ask the question, “how does one learn to live?” (p.47).

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Chapter 3: Ethical Therapy as Language of the Other²

Abstract

Derrida tells us languages are bearers of culture that are never neutral but always political; they impose a kind of violence on the persons who speak them. If to speak a language is to participate in the political, then the challenge for psychotherapy becomes ethical: how to avoid forms of linguistic oppression that impose a language on others. Such ethics takes precedence over questions of epistemology and technology in therapy: theory, knowledge and language are in the service of others. We speak the language of therapy so others can speak their own discourse and form their own language community. However in order to be called a therapist and be responsible for helping others one must learn to speak the language of therapy, which in Derrida's terms sets up a familiar aporia. In therapy we become masters of a language in order to give it up as servants of the persons who consult us. The language that constitutes our identity as therapists is there so we can speak the language of the other. This paper applies Derrida's notion of the language of the other as hospitality and the ethical relation to therapy. This has relevance for resolving an

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epistemological stand-off between modern scientific and postmodern relational paradigms in therapy.

Key Words: *Language, ethical, hospitality, Derrida, therapy, Levinas.*

Introduction

In *Monolingualism of the Other* Derrida describes a deconstructive paradox or antimony, whereby the languages I speak and call *mine* and form my personal and cultural identity are *not mine*, in the sense they derive from the wider culture or society and belong not to me but to those to whom I speak them. In this way all language, like the French Derrida learned to speak growing up as a Jew living in Algeria, involves a double movement. Language can be seen as a form of cultural hegemony or colonization that is imposed as a monolingualism *of the other*. Yet following Levinas, Derrida also defines language as hospitality, insofar as it belongs to the other and is spoken not for ourselves but always in relation to and *for* others.

The paper applies this aporia to a long-standing breach between modern and postmodern language paradigms in psychology and therapy. In this theory debate a scientific, interventionist and evidence-based paradigm is *opposed* to a relational, dialogic and narrative therapy framework. On the one hand modern therapists adhere to a scientific realist epistemology that privileges their own knowledge, expertise and power to intervene with psychological

problems like depression and anxiety. On the other postmodern therapists espouse a relational, dialogical and social constructionist epistemology, which gives priority to addressing issues of power, relationships and enhancing the marginalized voice of others. Yet from the perspective of practice both approaches can help to relieve psychological suffering and many therapists today work within *both* paradigms at once, despite the theory politics.

Following Derrida the paper suggests the aporia between hegemony and hospitality in language cuts across the modern versus postmodern distinction in therapy. Here the particular theory, paradigm or language used by therapists matters less than *how* they are applied or whether they are spoken as a language of hospitality. As for Levinas the ethical relation to the person takes precedence over epistemology or theory; therapists need not reject an objective knowledge or scientific technology but put ethics *first*. While therapists are monolingual in order to alleviate human suffering, these languages belong to and are spoken *for* the other as hospitality.

In this way therapists can be both modern *and* postmodern and draw upon *many* languages, theories and paradigms at once. This integrative, deconstructive or *paramodern* stance is illustrated by a detailed example from the contemporary practice of therapy.

The language of the other

Derrida tells us languages are bearers of culture that are never neutral but always political; they impose a kind of violence on the persons who speak them:

“Every culture institutes itself through the unilateral imposition of some “politics” of language. Mastery begins, as we know, through the power of naming, of imposing and legitimating appellations” (Derrida, 1998: 39; hereafter cited as *MO*). For Derrida there is a ‘traumatizing brutality’ to the way language can be used to impose political and colonial experience on others, which is the case not just in French history but across all cultures. Thus in Brian Friel’s (1981) play *Translations*, surveyors from the Royal Engineers in Ireland construct maps replacing Gaelic with English names; for example, ‘Muineachain’ becomes ‘Monaghan’. What appears to be a straightforward administrative task of renaming becomes at another level a violent replacing of one language and culture by another.

As Derrida says language concerns possession; it possesses us and is the means by which we possess. Along with colonial expropriation goes ‘linguistic oppression’ and power, which is what he calls the “terror inside languages” (*MO*, 23). This involves an appropriation of the other, a cultural rape or usurpation, a colonization in which what is not mine is imposed as if it were my own. Derrida is referring to his own experience as an Algerian Jew being compelled to learn the French language and literature at school. However his wider focus is the colonizing role of language as a bearer of political, cultural and psychological identity.

Derrida’s concern is a ‘monolingualism imposed by the other’, a form of philosophical and cultural hegemony, where language is used as an

instrument of restriction, exclusion, mastery or oppression. This is discourse that is violent, speaking for the other instead of inviting them to have a voice. It reduces the ‘many’ possible languages available to just ‘One’ original or pure way of speaking, which shuts down rather than opens up difference.

As Derrida says ‘deconstruction’ challenges the “compulsive demand for a purity of language” (*MO*, 46), particularly where it closes off meaning in a culture or institution, thus “effacing the folds and flattening the text” (*MO*, 40). For Derrida language is not about *the* correct or pure way of speaking, but being open to the rich diversity of tone and rhythm involved in writing and conversation: “Everything is summoned from an intonation. ... And even earlier still, in what gives its tone to the tone, a rhythm. I think that all in all, it is upon rhythm that I stake everything” (*MO*, 48). In other words what is said is less important than *how* it is said, where the priority is the speaker’s “relationship” and “openness to the other” (*MO*, 40).

This is an ethics of dialogue that Levinas (1969) calls *Saying*, the relational context for speaking to another human being, the welcome offered to another person as uniquely and strangely other: “We call justice this face to face approach, in conversation” (71). For Derrida as for Levinas, language has an ethical curve, in the approach, attunement, relationship and responsibility of one interlocutor for another. In *MO* Derrida proceeds to lay down a Levinasian riff of language as hospitality, the language I speak and call my own is not *mine*, but belongs to the other: “We only ever speak one language-and, since it returns

to the other, it exists asymmetrically, always for *the other*, from the other, kept by the other. Coming from the other, remaining with the other, and returning to the other” (*MO*, 40).

In Derrida’s subsequent work *Of Hospitality* this becomes a more solid groove, where he explicitly defines language as an ‘ethics of hospitality’ (Derrida, 1995a, 65): “As Levinas says from another point of view, language *is* hospitality” (135). The link is further established in *Adieu: To Emmanuel Levinas* where Derrida (1999) reiterates that language *is* hospitality, it is an asymmetrical relation of welcoming and receiving the other.

Now both these perspectives, one that highlights the risks of language as monolingualism or cultural hegemony, the other defining language in terms of hospitality are brought together in Derrida’s antimony: “Yes, I only have one language, yet it is not mine” (*MO*, 2). The first part of this proposition tells us the one or particular language I speak *is* ‘mine’, insofar as it constitutes me as a person. Here Derrida confesses to his “‘own’ monolingualism” (56), which is expressed by his attachment to and love of the French language and a secret obsession with speaking its phonetically pure form, even though this may be culturally imposed. Such a compulsion co-exists with the second ‘ethical’ step of the proposition, where my language is not mine but is spoken for others. This forms the aporia or antimony, while we only speak one language that is our own, we never do so, because the language we speak is always the language of the other.

In cybernetic or systemic terms that Derrida is fond of using (48), there appears to be a reflexive or circular loop between the notion of language as ‘mine’ and as belonging to the other. One is intricately connected to the other. It is only by learning to speak the other’s language, in the first instance that of one’s parents, family and culture, that the language I speak becomes my language. That is, my language is *first* of all the language of the other. Yet to speak the language of the other, one must first be able to speak or have a language called ‘mine’, even though this is already the language of the other. And so it goes round.

This aporia or antimony is also presented by Derrida in terms of simultaneously holding the following two contrary propositions: 1. We only ever speak one language. 2. We never speak only one language (MO, 7). Drawing on Khatibi’s work on bilingualism, Derrida implies there is no such thing as *the* language, a *pure* language and we never speak only *one* language; rather there are as many languages as there are people speaking them, even though they may share a common language, like French. In this regard Peggy Kamuf (2008) describes Derrida’s antimony, ‘I have only one tongue, it is not mine’ as ‘counter-Babelian’; it opens up the possibility of “a universal tongue, one which is universally translatable because it cannot be appropriated by any ‘mineness’” (150). Paradoxically we possess or call a language ‘mine’ only at the point where it is heard and understood by others. In other words language is not solipsistic activity but a living dialogue between persons.

In the last interview before his death, *Learning to Live Finally*, Derrida (2007) refers to the paradoxical aphorism, 'I have only one language but it does not belong to me' as a *hyperbolization* or rhetorical exaggeration. This emphasizes "a language is not something that belongs" (MO, 38) but is a dialogic responsibility of one person for another. It is in this ethical sense that the language I speak and call my own is *not* mine but belongs to and is spoken *for* the other.

To summarize the discussion so far, Derrida's antimony of language brings together two entirely contrary ideas. One highlights the risks of monolingualism where language is a form of cultural hegemony that imposes its 'one' 'pure' way of speaking on others. The second offers a Levinasian understanding in terms of hospitality, where the language I speak and call 'mine' is the language of the other. That is, language involves a *double* movement as both hegemony *and* hospitality; it is both mine *and* belongs to the other. Or it is mine when or because it is spoken for the other. In this deconstructive movement these two propositions come together despite the contradiction and tension.

In the non-symmetrical relationship of hospitality, the language that I possess and possesses me to construct my cultural and subjective identity *first* belongs to the other. In the both/and logic of deconstruction, the one language I speak and call 'mine' is *at the same time* an expression of hospitality as the

language of the other. To be able to speak at all, to call a language mine, I am required to speak a language that is ‘not mine’ but the language of the other.

The ethical challenge for therapy

If language is the medium through which a politics of cultural violence is enacted then what about the language of therapy? When therapists identify with and promulgate a particular therapeutic language as theirs or ‘mine’, is it not akin to being possessed and taking possession? Certainly Derrida’s *monolingualism* alerts us to the potential violence of all language, particularly when it is brutal, “impoverishing, repetitive, mechanical...does not open the future, does not leave room for the other ...and effaces singularity” (Derrida and Ferraris, 2001, 92). And like all theoretical or professional discourses, the language of therapy carries an institutional power and authority that can override the person.

As the psychiatrist John Heaton (1988) noted in a seminal chapter on Levinas and therapy: “The Other cannot be described or subsumed in the theoretical language which is used in most psychotherapy... Psychotherapy, wherever it looks, only finds itself: a form of violence to the Other”

(6). Likewise I will argue for any therapeutic approach, whether it is modern or postmodern, there is the risk of persons being subsumed by the very language that is meant to assist their suffering.

In these terms the challenge for therapy becomes ethical: how to minimize its expression as a form of monolingualism with the potential to

oppress others? As Derrida expounds Levinas, this concerns how a language of therapy can be understood and applied “in terms of non-violence, peace and hospitality” (MO, 92). Before anything it should produce a positive relation to the other, a welcoming or coming together, an ethos or place for the other to dwell and speak their own language. Therapists resist imposing their own language, power or agenda by opening up a dialogic space for the language of the other. This is a hospitality that reaches over the abyss of Babelian separateness, as a way of connecting and communicating with a fellow human being.

In such an ethical or ‘non-brutal’ approach, therapists become masters of a language in order to be servants of the persons who consult them. The various theories, models, approaches, frameworks or dialects of therapy they use address the question of ethics or justice, namely that others do not yet have a narrative voice to call their own. The particular languages that therapists speak, call ‘mine’ and form their professional identity *first* allow them to speak the language of the other. In other words ethical therapists take care not to use words like bullets. Maps therapeutic or geographic are useful, but like the experience of the Irish or Derrida for that matter, they can too easily become linguistic instruments of cultural violence and oppression.

In this ethical understanding therapists are wary about replicating the dominant culture expressed in the languages of psychology and therapy. There are already too many languages in the world vying for influence over a

bewildered populace living in the shadow of the tower of Babel. As Derrida says:” Today, on this earth of humans, certain people must yield to the hegemony of dominant languages. They must learn the language of the masters, of capital and machines; they must lose their idiom in order to survive or live better” (MO, 30).

Therapy should be a place where persons can find their own voice, tell their own story and be in touch with their indigenous culture. From this perspective the various psychological and therapeutic languages therapists inhabit and use to influence people’s lives should first enact an ethics and justice. Following Derrida, the language of therapy has a priority that “opens out onto a politics, a right, and an ethics” (MO, 24). This enacts an ethic of hospitality where: “My language, the only one I hear myself speak, is the language of the other” (25).

This understanding of language as hospitality takes precedence over the institutional authority of a therapeutic discipline or discourse: theory, knowledge, technology and language are used in the service of others. The reason I speak a language of therapy is to encourage others to speak their own discourse and form their own language community. The ethical relation to the other comes before epistemology, knowledge or theory. As hospitality, therapeutic language is a gift that belongs to the other, or as Derrida’s groove goes: “language is for the other, coming from the other, *the* coming of the other” (MO: 68).

An ethical dilemma

Nonetheless this poses an ethical dilemma for a therapist that mirrors Derrida's antinomy. In order to alleviate the psychological suffering of others, therapists are required to learn and apply the language, knowledge, expertise and technology of a particular therapeutic discipline or discourse. To be called a 'therapist' they need to be monolingual or know how to speak at least *one* therapeutic language in an expert way that has its origin in the culture or profession of therapy. This might be the discourse of biological psychiatry, scientific psychology, cognitive therapy, systemic family therapy or psychoanalysis, and so on. However it is precisely why persons suffering psychological distress have consulted a therapist in the first place, instead of a friend, neighbor, priest etc.

Unless therapists speak a pure 'therapeutic' language of one kind or another they would abrogate their ethical responsibility to help others in the best way possible. Levinas (1984) emphasizes a similar obligation as follows: "This is the great paradox of human existence: we must use the ontological for the sake of the other, to ensure the survival of the other we must resort to the technical-political systems of means and ends" (p.64). It would seem to speak a pure ontological or mono- language of therapy is a necessary condition for enacting hospitality in a therapeutic context.

For example, if a person is suffering a serious psychological problem like depression, therapists have a professional responsibility to

consider a range of therapeutic languages, enquiries and interventions. This obliges them to speak a singular therapeutic language, which engages a technology and expertise with healing potential and draws on the accumulated knowledge and expertise of the profession. This is likely to include therapeutic approaches shown by science and evidence-based research to be effective. For as Caputo (1997) notes: “The last thing Derrida is interested in doing is undermining the natural sciences or scientific knowledge generally” (p.3). The ethical challenge is how therapists can use such professional discourses to help the suffering of others, while minimizing their colonizing effects?

This meets Derrida’s aporia head on and takes us back to the question we started with. To speak a language is a power; the question is how to speak one language without silencing another. How do therapists prevent the knowledge and languages they *have* to speak, that define who they are as professionals from becoming hegemonic? How is it possible to be monolingual, to speak a therapeutic language called ‘mine’ *while* speaking the language of the other in a gesture of hospitality? While there is no easy answer, this is a dilemma that confronts all therapists in a practice context. It involves a politics of relationship as Derrida says, or how the speaker of one language relates to the speaker of a different language. It concerns how a therapeutic language is applied, the tone and rhythm of speaking, the extent to which we engage the language of the other and take on board their way of thinking and speaking.

In this relationship ethic the discourses of therapy belong to the persons to whom they are spoken. Even though therapists are monolingual in using a particular language of therapy, they are dialogical by speaking it in such a way that the listener hears the reflection of their own narrative voice and meaning. This is possible only where the therapist's relationship to the other is put *first* before the application of a therapeutic knowledge, language or technique. Following Derrida and Levinas the therapist's use of a language is a *response* to the other, which allows understanding, empathy and dialogue to develop in the relational encounter.

In one sense this is just good therapy practice; it is the art of applying a therapeutic language or technique in a person-centered and relationally sensitive way. Here the kind of language that is used matters less than ethics or *how* it is applied; that is, whether it colonizes in the name of knowledge, science or theory or respects and engages the language of the other. This recognizes a double ethical imperative. One is to help human suffering using the most effective science and technology of therapy available, the other is to do so in a way that facilitates the narrative voice and agency of the other.

In these terms the ethical relation of hospitality provides a relational ground for a monolingual therapeutic language to be applied with the least violence possible. It is in this sense that the languages I speak and form me as a therapist are both mine *and* not mine. They are mine most of all when they are not mine or belong to and are spoken *for* the other. Back to Derrida again: "My

language, the only one I hear myself speak and agree to speak, is the language of the other” (MO,25).

Deconstructing modern/postmodern therapy

In this section I suggest Derrida’s antimony of language helps to resolve a breach between modern scientific and postmodern relational paradigms of therapy, which still divides the field after more than two decades. On one side of this great theory divide are *modern* scientific therapists who tend to be strategic, interventive and work from an instrumental position of expertise, knowledge and power. As ‘scientist practitioners’ they apply ‘evidence-based’ psychological treatments that scientific research has purportedly shown to be effective using randomized controlled trials, as in medicine. In mainstream disciplines of psychiatry and clinical psychology, pharmacotherapy and cognitive-behavioral therapy are typically prescribed for psychological conditions such as depression, psychosis, bipolar disorder etc. In the modern paradigm, the self is described as autonomous, centered and rational, with psychopathology formulated largely in terms of impairments or deficits *within* the individual, whether at the level of neurobiology, biochemistry, cognitions, emotions and behaviour.

In contrast *postmodern* relational therapists coming from a background of family therapy, narrative therapy, social constructionist or critical psychology, apply dialogic, cultural, narrative and language-based metaphors to describe human suffering and experience (Anderson, 1997).

Persons are not seen as unitary, rational and independent subjects, but as ‘relational beings’ formed through ongoing connection, dialogue and conversations with others (Gergen, 2008). As one pre-eminent social constructionist in the field of psychology noted, the modern, Cartesian or Enlightenment view of mind or self is replaced by a “whole dialogical view of language, mind, meaning, and selfhood, focusing on events occurring out in the world between people” (Shotter, 1999, p.71).

Postmodern therapists draw on philosophers like Bakhtin, Voloshinov and Wittgenstein, to describe therapy as a collaborative exchange or dialogue between living persons (Rober, 2005). The approach to therapy is collaborative, ‘not-knowing’, curious and benign, rather than scientific, instrumental or interventive, which provides a dialogic space for persons to construct new identities and re-author alternative stories. Here the cultural discourses that locate psychological problems *in* the person are ‘deconstructed’ or unpacked in order to emphasize the textual, linguistic, storied and relational construction of lived experience (White, 2000).

Now for the everyday therapy practitioner both a scientific *and* a relational perspective have something to offer and indeed in practice many therapists draw on both paradigms at once, despite the theory dissonance (author, in press). The impasse arises when modern therapists dismiss relational therapy as ineffective or unscientific and postmodernists in turn advocate abandoning a modern scientific psychology and therapy in favor of a social

constructionist, relational or narrative paradigm. It is the author's contention that adopting either theory position too rigidly risks imposing what Derrida (1998) calls a 'monolingualism of the other' or a pure 'language of the same'.

Deconstructing the modern scientific-practitioner model

Such a 'politics of language' is evident in the narrow definition of a scientist-practitioner model by modern clinical psychology based on an exclusive positivist philosophy of science. In its attempts to regulate the profession only psychological techniques that have been manualized, subjected to strict experimental or scientific control and tested on specific clinical populations using randomized controlled trials are allowed to join the 'evidence-based' club. This constructs the gateway for practitioners to join the discipline, qualify for health insurance and receive government funding for providing psychological services (author, 2004).

However human psychology and therapy is a more complex affair than a traditional scientific paradigm allows. In real life practice settings, clinical presentations typically involve individual, relational and contextual variables that cannot easily be brought under scientific control without sacrificing relevance or validity (author, 2001; 2004a). As a major reviewer of evidence-based therapy for children and adolescents Kazdin (2003) comments: "The ways in which psychotherapy is studied depart considerably from how treatment is implemented in clinical practice. Consequently, the extent to which

findings can be applied to work in clinical settings can be challenged ...”
(p.259).

In Derrida’s terms a rigid interpretation and application of the scientist-practitioner model is like a ‘colonial power’ that reduces the language of therapy, “to the One, that is, to the hegemony of the homogenous” (MO, 40). In its quest to be recognized as a science, the modern psychology dismisses other therapy paradigms and marginalizes qualitative forms of research that shows relational therapy is effective. It also minimizes consumer feedback, the collective wisdom of practitioners in the field and research demonstrating the existence of common factors between all therapy approaches. This shows therapist attributes like empathy, the quality of the therapy relationship, a person’s expectations, sense of hope and their relational and life context, contribute significantly more to therapeutic change (85% of the outcome variance) than the specific technique or model of therapy used (Hubble, Duncan and Miller, 1999).

To deconstruct the scientific paradigm in therapy is to demonstrate what Derrida calls a ‘*performative or pragmatic contradiction*’ (MO, 3) at the heart of its practice. This traces an alternative story in the margins of therapeutic practice, as the common factors research suggests. Thus in the real life treatment of psychological problems like depression, the therapeutic relationship between the therapist and client is paramount and therapists are often required to tailor an evidence-based treatment approach to fit the person

and the situation. Effective therapy requires the use of *many* languages to describe and treat human suffering, which include the scientific as well as relational, systemic and narrative ways of speaking and knowing. Despite the theory division, in practice many therapists apply modern scientific therapeutic interventions *while* taking on board relational perspectives of the other (author, 2001; in press).

Deconstructing postmodern therapy

On the other hand the monolingualism described by Derrida (1998) is apparent when *post*-modern therapists urge a radical shift away from a modern science of psychology to a social constructionist, relational or narrative paradigm. This also proclaims *one* language for describing the world, replacing a scientific with a social constructionist epistemology in the notion of relational being (Anderson, 1997; Gergen, 2008). For example, social constructionists Katz and Shotter (2004) describe a conversational, dialogic or “social poetics” approach to therapy, where the therapist’s “expressions or utterances must only be voiced in response to the utterances or expressions of those we address (p. 74-5)”. They note an ethical violation of the other, where therapists step outside this back and forth dialogic response to *impose* a theoretical hypothesis or suggest a therapeutic intervention.

However as Levinas (1984) describes the ethical relation, therapists also have a responsibility to think about what might reduce human suffering in the most effective way possible. The greater challenge is for therapists to be

dialogically responsive in face to face conversation with the other *and* utilize what they know, in terms of training, research and the technology of the profession. In terms of Levinas (1969) to put the relation to the other or ethics *first* doesn't preclude the use of more objective forms of knowing (the Said) in the form of therapeutic ideas, hypotheses and interventions. Indeed to privilege the relational/narrative paradigm *over* objective scientific knowing merely inverts the modern/postmodern binary or hierarchy. Whereas to deconstruct it is to show one position or term is in dialogue and relationship with the other, despite the dilemmas, impasse or aporia. As Derrida (1998) notes 'deconstructive writing' necessarily works within "the philosophical tradition that supplies us with the reservoir of concepts I definitely have to use" (p.59).

To advocate *replacing* modern languages of therapy like biological psychiatry, neuroscience or cognitive therapy with a dialogic or relational paradigm merely repeats the hubris of modernism. I call this the postmodernist fallacy because it represents yet another violent *break* with prior knowledge that substitutes one 'pure' or dominant language with another (author, 2001). This very move of replacing a previous (medieval) worldview or language with 'the new' is what defined the modern. From the ethical perspective of deconstruction the post-modern can be seen as yet another attempt at mastery, another instance of violent inhospitality, where one language or theory exerts power or dominance over another. This is doubly ironic given that postmodernism champions the idea of *many* truths, realities or stories.

Therapy as more than one language

Derrida's (1995a) work is distinct from a postmodern position, which is why he says: "To deconstruct is a structuralist and anti-structuralist gesture at the same time" (p.83). Again Derrida (1995b) states his position clearly: "Postmodern is a word that I have never written, and modern almost never" (p.47). He challenges the notion of a *post-modern-* 'ism' as an era beyond the modern. Such binary splitting between past and future, modern and postmodern is precisely what requires deconstructing. It is yet another attempt to institute monolingualism.

Over the years Derrida has challenged the popular misconception of deconstruction as an iconoclastic method or critique, which 'takes apart' and replaces modern thought, texts, institutions or cultural discourses. Far from being about destroying modern meaning deconstruction concerns exactly the opposite: "Deconstruction, let's say it one more time, is not demolition or destruction" (Derrida, 1995a, p.211). For Derrida (1997), the purpose of deconstruction is not to destroy traditions but "to open the institution to its own future" (p.6). To deconstruct is to honor the vision, to stay within and preserve a tradition or language, *while* simultaneously moving towards a new and more open conception or organization.

In these terms to deconstruct modern therapy is not to replace it with a postmodern paradigm, but to add to what is already there. There is a culture of respect for a language tradition in which future ways of speaking are intimately

connected to past voices of knowing. This challenges the idea that therapy progresses only through crisis or revolution where one paradigm or language replaces another. The deconstructive question for a discipline like therapy is not which epistemology, modern or postmodern is predominant, but how it can be *open* to its own destiny or future.

Here I want to suggest the various languages of therapy co-exist in a strange tension that is both modern *and* postmodern at the same time and likely to give birth to something else. I call this deconstructive stance *paramodern*, (author, 1994), where the prefix *para* means, at the same time, both beside (e.g. paramedical) *and* beyond (e.g. parapsysics or paranormal). To be paramodern is to sit with the tension, contradiction or aporia between a modern scientific therapy and its description as a social constructionist, relational or narrative endeavor. It is a both/and stance that doesn't reject the modern science of therapy but colors it with a postmodern brush, adding ecological notions of context, narrative and relationship. This allows practitioners to access the scientific knowledge and techniques of modern therapy *and* the relational, narrative, dialogic or social constructionist metaphors of a postmodern therapy. What is deconstructed is the monolingualism of either/or, which constructs a theory and practice division between modern and postmodern languages of therapy.

From a deconstructive perspective all languages, discourses and theories, whether modern or postmodern, can be seduced by a sense of their

own purity and exhibit a messianic zeal or ‘colonial hegemony’. This is why Derrida (1998) says: “As I do in all fields, I have never ceased calling into question the motif of “purity” in all its forms... (p. 46)”. For Derrida (1998) the deconstructive challenge is not to find *the* correct way of speaking but to demonstrate a rich diversity of language at play in a discipline or institution. It is for this reason he offers what he calls a simple and brief definition of deconstruction as “both more than one language and no more of just one language” (Derrida, 1995c, p.28).

I take this to mean where there are *many* languages and not just the *One*, others can be invited to participate in a conversation or discourse. If therapy is more than one language persons have the freedom to develop their own vocabulary and metaphors for change. There is room for the client’s language *and* for the therapist’s language; in therapy both come together in dialogue. Where there is no longer a dominant pure language of therapy, not *one* but *many* ways of speaking, the other can be encouraged to appropriate and construct their own language for agency and change, one which they can call ‘mine’.

Practice Illustration³

Clare was referred at 14 years old for depression, bulimia, suicidal thoughts and frequent self-harm involving cutting with scissors on her wrist and arms. As she

³ This is a constructed therapy narrative based on a collage of therapeutic stories with personal details changed to preserve confidentiality.

explained in our first interview: “I get depressed, try to commit suicide and throw up”. Concerning her depression she said: “I get so depressed I can’t feel anything or I can’t stop crying”. In relation to suicidal thoughts she noted: “I don’t want to be on this earth any more, everything is going bad, and my friends hate me”. Clare had considered jumping off a cliff, shooting herself or cutting her wrists. There was a disrupted family history with her upbringing shared between her grandparents and single-parent mother, who also suffered depression and was a victim of violence in a series of unhappy relationships. In the mother-daughter relationship there were serious parenting and attachment issues with a history of chronic conflict. As Clare said: “We fight a lot, more like sisters, she doesn’t like being a parent, and I’ve taken the parent role”.

In my initial interview with Clare with the team psychiatrist, she was diagnosed with depression, deliberate self-harm, as well as bulimic symptoms and panic episodes. A trial of antidepressants and therapy was recommended and I saw Clare intermittently over a period of several years. The treatment approach combined medication, individual therapy combining cognitive-behavioral and a psychodynamic approach and family therapy to address issues in the mother-daughter relationship. Clare was an excellent artist so I utilized art therapy to encourage narrative expression of her emotional experience and story. At the same time evidence-based cognitive-behavioral therapy, which has been shown to help young persons with serious depression, offered tools to help change her thinking, emotional and behavioral patterns

(author, 2009). The family therapy helped Clare and her mother to resolve their relationship, conflict and attachment issues. I also saw Clare's mother for several sessions to provide information about managing adolescent depression and discuss parenting issues such as discipline and establishing clearer parent-child boundaries etc. As well there was liaison and consultation with the school psychologist and Clare's doctor with her permission.

The therapeutic approach utilized modern therapy techniques at the same time as having a relational and narrative focus from a postmodern or social constructionist perspective. This gave priority to the therapeutic relationship and established an adolescent-friendly space for dialogue to occur (Rober, 1999), which encouraged Clare to construct an alternative self narrative and find her own language to speak her emotional and psychological pain. Such an *integrative* therapy approach has been shown to be effective in working with depressed and suicidal adolescents and their families, especially where serious attachment, family, relationship and personal difficulties are involved (author, 2009).

As mentioned Clare was interested in art and in one of our early sessions I asked her to draw a picture to represent her depressed and self-harming feelings, which she called *The Whirlpool*. In the picture the words help, lost, die, blood, punishment, found, hurt, pain, cry, and CUT and NEED in big letters, swirl in concentric circles on a yellow background around a large knife with the word "Relief" written on its blade and a large pair of scissors. I asked

Clare to write about her drawing which she described as follows: “In the picture with the whirling water, it shows that you start a whirlpool of depression. The whirlpool I’ve drawn is the last end of the whirlpool when you’re desperate. Desperate to cut, to die and you really need help. I call it a whirlpool because you have to be strong and fight it as it comes up on you. You feel numb before you cut yourself almost like you’re not even there. When you do it you can do it for relief or punishment or it can make you feel like you’re found again and no longer lost. That’s all the confused feeling you have inside you when you think about doing it. I get the idea of red blood running down then I looked at it. There are colors to express confusion and pain, happiness etc. This is what I feel when I slit my wrist”.

Over the course of two years Clare’s depression and self harm behavior significantly improved, although at the age of sixteen years she presented with another serious episode following a break-up with her boyfriend. Again I encouraged her to draw her experience, which she depicted as a tiny dot labeled ‘Me’ in the middle of a page covered completely by grey dashes of rain. Clare said this represented her feeling overwhelmed by a deluge of recent life experiences, which had reduced her sense of self to one of insignificance and worthlessness. Taking in this pictorial metaphor and making her language ‘mine’ I asked her a general question: “What helps to protect you from the rain?” She answered an ‘umbrella’ and I suggested we construct a metaphorical umbrella, where each spoke represents an aspect of her life that has provided a

sense of resilience, strength, support and hope in her life. These ‘spokes’ of resilience identified milestones like her progress in managing her depression (e.g. through her art, cognitive therapy and medication), her school achievements and developing aspirations for a career, an improved relationship with her mother, her ‘circle of friends’ who provided emotional support, and so on.

As a therapist I am welcoming towards Clare in the therapeutic relationship and oriented towards her preferred way of speaking, such as art. Yet the various languages I speak as a therapist, my knowledge and expertise in working with depressed teenagers, are there as well; they enable me to ask questions, offer interventions that can help to alleviate her emotional suffering and develop ideas like the umbrella metaphor. They fulfill an ethical and professional obligation to help Clare to manage her depression and suicidal risk in the most effective way possible.

My professional, therapeutic and ethical responsibility is clear: to monitor, manage and treat Clare’s depressive symptoms and suicidal risk within a framework of modern psychiatry, therapy and crisis management. Yet the use of modern scientific techniques like cognitive therapy and pharmacotherapy is integrated within a postmodern relational, narrative and dialogic approach to therapy. The ethical relation is enacted in terms of *how* therapeutic language or knowledge is used, where the language I call mine and forms my professional identity is first and foremost the language of the other. Here the various

monolingual languages I speak as a therapist are applied as an ethic of hospitality.

Therapy as ethical relation

In the ethical relation the therapist puts the other *first*, before a preferred epistemology, language, theory, model and paradigm of therapy, whether it is modern or postmodern. What is important is less epistemology and more the ethical, not what we know but *how* we speak in relation to others. Following Derrida this recognizes all language involves a politics of violence, one which is tempered only where the following refrain or rhythm holds true: “My language, the only one I hear myself speak and agree to speak, is the language of the other” (MO, 25).

As Derrida cites Levinas, the ‘essence’ of language is ethics or “friendship and hospitality” (MO, 90-1). If language is hospitality, then I am a therapist most of all *when* my language is at the same time the language of the other. I adopt the other’s language and make it my own and hopefully they reciprocate in being hospitable towards the language of therapy I am using. However in doing so I do not give up the various languages I speak as a therapist, but *at the same time* speak the language of the other. In this sense therapists are required to be multilingual.

In the ethics of deconstruction therapists utilize *more than one* language at once despite the aporia or tension, all of which are spoken *for* and belong to the other. This epistemological stance is modern *and* postmodern at the same

time, or as the author calls it *paramodern*. The therapist responds to the other in face to face conversation *and* utilizes modern scientific interventions and techniques where appropriate. The approach of the ethical therapist to language is both monolingual *and* hospitable. As the practice example illustrates this double movement is required to help human psychological suffering like ‘depression’, where the modern (hegemonic) language of therapy is not abandoned but enriched by and open to the language of the other. This offers the possibility of relational meaning in the therapeutic dialogue *and* effective intervention.

As we have seen this follows the ethical imperative of Levinas to *respond* to the suffering of others in the best way possible. In therapy we are obliged to *think* the other, in the sense of taking in their emotional suffering and reflecting on it *as if* it were one’s own. At the same time we resist such schematization as an impoverished attempt to represent the other in categories or thought. This recognizes the other is always *beyond* our understanding; otherwise he or she wouldn’t be *other*. Again in terms of Levinas: “To think the experience of the Other, which is nothing less than to think suffering, is to refuse to allow this thought to fall into the image of thought (Large, 2005, p.xiii)”. Yet for a therapist, to think the other using scientific categories of thought like ‘depression’ is a necessary part of responding to and assisting their suffering.

Thus Derrida (2000) refers to the contradiction, paradox or “aporia...of an ethics of hospitality” (p.65). In the present discussion this concerns how to

welcome the other into the house of therapy when our language and thinking as therapists keeps them outside as strangers? Yet it is this *aporia* of hospitality that defines deconstruction in the ethical relation, or as Derrida (2000) comments: “Now the impossibility of that “at the same time” is at the same time what happens” (p.125). Such an *aporia* is endured rather than resolved and in some way provides a way forward. The ethical therapist resists defining the singular and transcendent other within a theoretical framework of modern scientific psychology or therapy, yet has a responsibility to do so where this is effective in alleviating their suffering. In therapy this dilemma concerns how it is possible to have a relational, conversational and narrative stance *while* introducing modern scientific practice and intervention?

In terms of Levinas (1969) it is an issue of the therapist thinking reflectively in terms of objective categories (the Said) *while* being moved by and responding to the relational other (the Saying). The Saying is sacrosanct but as Levinas notes doesn't exclude the Said. Rather the relational, dialogic and ethical posture of the therapist is what allows more objective or scientific forms of knowing and speaking to be expressed or Said. In this way the therapist participates in a dialogically responsive conversation *and* contribute ideas, hypotheses, effective interventions and the like, as long as these are not imposed on others in a categorical way.

Conclusions

In conclusion what is relevant in the ethical relation is *how* therapists use modern and postmodern knowledge, rather than making an either/or choice between these different knowledge paradigms. The challenge for the discipline is whether the various languages of therapy can extend citizenship to each other, rather than to dominate or possess, to be hospitable (author, 2003). Here the monolingualism of the other, whereby a discipline, theory, paradigm, language or institution takes on “the threatening face and features of colonial hegemony” (Derrida, 1998, p.69) is resisted, yet monolingualism in the form of a language of effective intervention is part of an ethical stance of hospitality.

This reading of the ethics of deconstruction is an argument for theory and practice diversity in psychology and therapy. Where there is no such thing as a dominant or pure language there can be a diversity of metaphors, all of which add to the conversation about therapy. In deconstructing therapy we are mindful of the politics of imposing *one* language on the other, whether with clients in therapy or with colleagues in the theory and practice of the discipline. Following Derrida to deconstruct is to engage a diversity of practitioner knowledge in the profession both modern *and* postmodern at once. It is to introduce *more than one* language into therapy as a gesture of the ethical.

This articulates the relational and dialogic face of the discipline of therapy while respecting and engaging with its scientific and empirical foundations. The various languages and metaphors of science, systems, relationships, dialogue and narrative are all part of the living vocabulary of

therapy. What this means is that many languages are available to speak therapy, precisely because there is no longer only one, except the language of the other. As in the above example of treating depression, this allows therapists to access a rich diversity of knowledge, models, techniques and languages.

To acknowledge there is not one language (mine) but *many* languages belonging to others *is* to be ethical and enact justice. In therapy deconstruction opens up meaning for persons, families, texts, institutions or the discipline in a way that has ethical and political implications. The ethical concerns *how* people can be in relationship and dialogue with each other, which is also the concern of therapy. In Derrida's terms this is possible where as a therapist my language is *at the same time* the language of the other.

Notes

1. In various works Derrida makes reference to Gregory Bateson the anthropologist who is a key thinker in systems theory and cybernetics and the development of family therapy. Derrida was familiar with post-war cybernetics, including Bateson's work on the double bind and often used the language of systems thinking to explicate the workings of deconstruction. For example, in *Resistances of Psychoanalysis* (1998) he mentions Bateson directly by name: "...beginning with Bateson and others, it is assigned (the double bind) a schizogenic power to which some fall victim while others are immune (p.36)". In a move Bateson may have appreciated, Derrida extended the idea of the double bind beyond relational pathology to refer to the paradoxical interplay or *aporia* between structure and free play in a language, text or

system. What is interesting is that for Derrida as for family therapists influenced by Bateson, meaning is relational, con-textual or systemic.

2. Here it is instructive that the word 'Babel' derives from the Hebrew verb *balal* "to confuse and confound", which was God's purpose in destroying the idolatrous Tower of Babel. As it says in *Genesis 11:9*: "Therefore is the name of it called Babel; because the Lord did there confound the language of all the earth: and from thence did the Lord scatter them abroad upon the face of all the earth". An entirely opposite or counter-Babelian experience is described in *Acts 2:4* on the day of Pentecost: "And they were all filled with the Holy Ghost, and began to speak with other tongues, as the Spirit gave them utterance". While the apostles spoke in their own languages what the listeners heard was the sound of *their* own tongue speaking. Without wanting to push the theological connection too far, in the non-Babelian world of Derrida and the Gospels, language emerges dialogically out of a community of speakers as hospitality, where the language of the other becomes the sound of my own voice speaking.
3. The author's use of repetition here mirrors Derrida's in MO, where such statements take on the quality of a hyperbolic groove or rhythm.
4. An antimony is a double bind that is impossible to escape, yet for the sake of the other we must take a position. The dilemma is this. Therapy encourages others to speak and have a language and voice. As a therapist the challenge is how I can speak the language of therapy without imposing it on others as 'mine' as a monologue. It is impossible, that is what the antimony is about. This is the case no matter what languages therapists speak, whether they are modern or postmodern. Yet as Derrida often says the impossible is what deconstruction is about.
5. Here it is instructive the word 'therapy' derives from the Greek verb *therapeuo*, which means to heal, take care of or be *responsible* for the other.

6. This asks questions much like the following. Does the pattern of symptoms and/or family history suggest a biological depressive illness that might respond to psychiatric intervention like pharmacotherapy, especially where suicidal behavior is involved? This is a controversial issue for postmodern relational and narrative therapists informed by a social constructionist or dialogical framework, who resist applying diagnostic labels and categories with the potential to efface the person (Anderson, 1997). Nonetheless there is a positive side to having a negative psychological experience ‘named’ using a diagnostic term like ‘depression’. Both in terms of the sense of relief it can bring for the person and the range of techniques therapists can access to alleviate it. Here the person can be encouraged to think it is not ‘me’ but the ‘*depression*’ (the ‘black dog’ etc.) that explains how I behave or feel, which is an example of the use of language opening up rather than closing down difference. Other therapeutic enquiries might include the following. Can the depression be treated using an individual therapy approach like mindfulness-based cognitive therapy, which scientific research in psychology has shown to be an effective intervention? Are there ongoing relational or family difficulties contributing to the depression that might respond to marital or family therapy? Again an integrative therapy approach that combines family therapy, cognitive therapy and pharmacotherapy (where required) has been shown to be a best practice response for helping depressed adolescents (author, 2009). Where the depression is related to a disruption of relationship or attachment, like the loss of a parent or family breakdown in childhood, a psychodynamic based relational therapy could be helpful. Therapists also need to consider the possible role of social, economic and cultural factors in the person’s depression, for example, financial stress, unemployment, workplace bullying, institutional abuse, gender or racial discrimination, domestic violence, or past

traumatic experiences like being a refugee, imprisoned, tortured or a member of the stolen generation? And so on.

7. Like the astounded witnesses in the gospels who hear the apostles speaking in *their* language, which reversed the curse of the tower of Babel. Of course this metaphor opens up interesting parallels between therapy and theology as a community of speakers.

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Note: The references to the author's articles have been temporarily omitted to conceal identity for the blind review process.

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Chapter 4: The Ethical Play of Irreverence in Deconstruction and Family Therapy⁴

Abstract

This article celebrates the lives of two systemic thinkers who shared a theme of irreverence and the ethical in their work⁵. It links Cecchin, Lane and Ray's concept of irreverence in family therapy to the wider philosophical landscape of Derrida's deconstruction. The former argued against adopting fixed or rigid theory positions in family therapy that lead to futile play-offs and endless debates about which framework is true or 'correct'. They proposed a stance of irreverence or playful impiety toward any theory or idea that limits practice options for family therapists. This avoids divisive dichotomies in the field like between modern systems, strategic or structural approaches and a postmodern social constructionist or narrative metaphor.

Deconstruction introduces a sense of play and irreverence towards the dominant discourse of a text, theory, institution, approach or idea. Either/or dichotomies that define one way of thinking unpack into a both/and diversity of language and meaning as a play of differences. As Derrida defines it, deconstruction is an ethical relation to the other based on a gesture of responsibility and hospitality where the marginalized other is invited to have a

⁴ This paper was published in 2007 in *Human Systems: The Journal of Systemic Consultation and Management*, 2005, Vol. 16: 31-44.

⁵ Derrida died from pancreatic cancer in October 2004 eight months after Cecchin's tragic car accident.

voice. I explore the ethical play of irreverence as a guiding metaphor for contemporary family therapy.

Introduction

Over a decade ago Cecchin, Lane and Ray (1993) documented a philosophical standoff or theory demarcation in the field of family therapy; one that began in the mid-1980's and to some extent is still being played out today. On one side were first order cybernetic structural and strategic interventionists who advocated and to some extent still do (Minuchin, 1998), that family therapists are *instrumentalists* who wield power and influence to intervene in family and wider systems. On the other side of this theory divide postmodern therapists with a social constructionist and narrative epistemology cautioned against the use of power in favor of *non-instrumentality* and working with language and story in the therapeutic conversation. Theorists in this poststructuralist camp like Anderson and Goolishian and Michael White urged the discipline to abandon its traditional systemic or cybernetic thinking for a language of narrative and social construction. Instead of being experts who intervene in family systems, not-knowing and narrative therapists co-construct with their clients (typically individuals) a new language or story for change.

Now Cecchin et al (1993) argued that adopting an instrumental *or* a non-instrumental position could be equally rigid and limiting for family therapists. While it is true strategic interventionists risk abusing their position of power and

becoming agents of social control, at the same time family therapists are often required to act as experts and intervene directly with families. This is certainly the case when working with psychological risk, physical and sexual abuse, relational violence, self-harm and suicidal behavior or in assessing and managing serious mental illness (Larner, 2003). To resolve what they saw as a futile play-off between instrumentality and non-instrumentality Cecchin et al (1993) proposed “the concept of *irreverence*, that is, impiety toward *any* idea that limits the options of the therapist (p.129)”. The irreverent therapist resists “becoming a true believer in any approach or theory (p.129)”. An irreverent stance means, “we are now ready to play (p.129)”, that is, “to juxtapose ideas that at first might look contradictory (p.129)” and to “be skeptical toward polarities (p.130)”. This allows the therapist and client system to be more creative and “evolve new beliefs, meanings, and less restrictive patterns (p.129)”.

Cecchin et al (1993) conclude their article with a both/and invitation to systemic practitioners “to consider freeing themselves from the constraints inherent in believing too strongly in either the position of strategizing or noninstrumentality (p.133)”. In other words family therapists can be both instrumental *and* non-instrumental; their stance towards theory can be flexible depending on the needs of persons in therapy. They might formulate a particular systemic hypothesis or use a specific technique or ritual to intervene in a family; what matters is whether they are playful or *irreverent* towards their beliefs and

take responsibility for their actions. Therapists can apply a particular idea or model in family therapy as long as they don't fall in love with or follow it 'too strongly or permanently'. This is a therapeutic stance that is both pragmatic and practice-based. As Cecchin et al (1993) say: "He/she can believe strongly in a model, or an idea, or hypothesis while being free to discard it when it is no longer useful (p.131)".

But it is also ethical in the sense that therapists are concerned less with changing others and more with the consequences of their own beliefs, prejudices and actions. The authors give an example of a family therapist working in a psychiatric hospital. Rather than being an ideologue or revolutionary who sets out to change the institution he/she introduces creativity and flexibility into the system by first being so themselves: "Our position is that we can only change ourselves; we cannot change the institution (Cecchin et al; 1993, p.132)". This positioning is not only ethical but also therapeutic. As Cecchin et al. (1992) state in their book *Irreverence: a Strategy for Therapists' Survival*: "Irreverence, as described here, is an attempt to recoup what for us is a more ethical deontological position...But it is at the moment when the therapist begins to reflect upon the effect of his own attitude and presumptions that he acquires a position that is both ethical and therapeutic (pp.8-9)". Indeed to be ethical in this sense of being irreverent, curious and playful towards theory and belief *is* the therapy, which is a theme I return to later.

Irreverence as best practice in family therapy

Now it can be argued that over the last decade the field of family therapy has developed much in the way Cecchin et al (1992; 1993) recommended. Previous fault lines dividing family therapists into one camp *or* another are being deconstructed as a more playful, flexible and *irreverent* stance towards theory has become evident. Historical polarities that fractured the discipline and marginalized it from mainstream therapy, like instrumentality versus non-instrumentality, scientific versus systemic, individual versus family work or biological versus systemic metaphors are now less contentious. Systemic family therapists today are more likely to utilize instrumental evidence-based approaches whether from within their discipline or without, the latter including pharmacotherapy, parent management training and cognitive therapy (Carr, 2000; Lerner, 2003a, 2004a). For example, the Maudsley approach to eating disorders integrates modern instrumental approaches like structural family therapy with non-instrumental postmodern narrative therapy in a scientific evidence-based model of care (Rhodes, 2003).

In recent years there has been an integrative revolution in the field taking family therapy beyond local theory and model squabbles in order to meet a bigger challenge (Lebow 1997). To survive in an evidence-based ‘therapeutic industry’ family therapists are increasingly required to believe in the so-called ‘illusion’ of control and influence. As Cecchin et al (1993) say; “We ourselves have been, and to some extent still are, happy victims of this seduction (p.127)”. In order to compete for resources and funding and be recognized as a viable

treatment alternative, researchers and practitioners are keen to show family therapy ‘works’, has an influence on therapeutic outcome and is *instrumental* in changing people’s lives. However this strategic sensibility has gone hand in hand with the non-instrumentality of a narrative and social constructionist approach. Thus while family therapists have been instrumental in establishing evidence-based credentials for the discipline, there has also been a systemic and social constructionist critique of a scientist practitioner model (Stratton, 2001; Eisler, 2002; Sprenkle, 2003; Larner 2004a). In other words contemporary family therapists are required to straddle both instrumentality *and* noninstrumentality much as Cecchin et al. (2003) advised.

In the current literature there is a healthy diversity of theory and frameworks being applied and developed across the gamut of the discipline. Contemporary family therapists are informed by a pragmatics of practice (Flaskas, 2002) and an *ethic of hospitality* towards other ways of thinking and doing therapy (Larner, 2003a). As recently noted by Speed (2004), systemic therapists in the NHS develop a collaborative relationship with mental health colleagues who use other approaches like psychodynamic or cognitive therapy. This respects model differences while looking for a common ground. Similarly Larner (2003a) argues that family therapists working in the mental health system today are expected in professional terms (particularly where risk is involved) to be instrumentalists, utilizing psychiatric-diagnostic assessment protocols and evidence-based treatments in a biopsychosocial model. Indeed

when intervening with serious mental illness or life-threatening issues like teenage depression and suicidality, instrumental procedures such as crisis intervention, psychiatric intervention, cognitive therapy and pharmacotherapy provide a much needed safety net for applying systemic and narrative approaches.

Thus Cecchin et al's (1993) concept of irreverence has been the spearhead for a third way *between* instrumentality and non-instrumentality in the field of family therapy. This has eschewed polarized theory or model positions for a more flexible, integrative and pragmatic response to the realities of contemporary therapy practice. Irreverence is a theory stance that is located *between* the instrumental and non-instrumental or the modern and postmodern as *paramodern* (Larner, 1994; 2004). It goes under various names like 'knowing not to know' (Larner, 2000a), 'safe uncertainty' (Mason, 1993), co-constructivism (Speed, 2004) or more recently theory 'promiscuity', where divergent therapy models inform practice as 'fluid and flexible resources for action in the therapeutic conversation' (McNamee, 2004). This is deconstructive in that it unpacks rigid either/or oppositional thinking in favor of a *both/and* approach that recognizes the complexity and diversity of meaning in therapy. It is also ethical in that therapists take responsibility for *how* they know and act in relation to others.

A respectful irreverence

Irreverence does not imply disrespect towards an idea, theory, approach or technique in family therapy, rather it challenges the belief that they are *true* in a modern sense. As Cecchin said in a recent interview with Bertrando (2004): “There’s no truth anymore, the truth is always eluding you: you go on searching, but you can’t find it. And it’s this research that makes the conversation therapeutic (p. 217)”. Irreverence disrupts the act of reverence as putting your faith in a dogma or certainty; it is not believing in an approach or idea that is the problem, but believing in it *too* strongly! To do so is to close off other possibilities and ignore the wider context of meaning as well as other voices in the narrative. Irreverence begins less with what others believe and more with what I believe; it respects the other’s way of thinking while challenging one’s own. By being irreverent towards one’s own dogma and prejudices there is room to be curious about what *others* think or believe. Paradoxically to be irreverent is to have a ‘deep respect’ as in one meaning of *revere* (Australian Oxford Pocket Dictionary) but not to worship⁶.

What irreverence challenges is the certainty of the *therapist’s* belief whether it concerns a systemic hypothesis or formulation about a family or a model of family therapy. Cecchin et al. (1993) put it like this: “In order to undermine the family certainty we must always question our own. The danger

⁶ There is room for a tempered ‘reverence’ in irreverence, the concept is self-reflexive or deconstructs itself.

lies in the idea that we may start believing too strongly in our ability to control or predict (p.133)”. Therapists can still have beliefs, opinions, hypotheses or approaches and even feel reasonably certain about their utility or validity as long as they don’t feel *too* certain. In other words irreverence involves a position of uncertain certainty or ‘safe uncertainty’, which operates *between* dichotomies of a binary pair such as certainty/uncertainty (Mason, 1993). The stance of the therapist is both knowing *and* not-knowing at the same time, what Lerner (2000b) calls *knowing not to know*. Here not knowing provides the narrative container for therapeutic knowing to occur as a collaborative exchange of ideas between persons. The therapist’s knowledge and expertise can be applied at an instrumental level, for example, in the case of providing best practice management guidelines for parents of teenagers with eating disorders, antisocial behavior or depression and self-harm and so on. What matters is *how* this therapeutic knowing is imparted; whether there is an openness, self-questioning and awareness of its impact on the person or family.

By being playful and irreverent towards their own knowing and truth the therapist helps the family to be flexible about their own beliefs, prejudices and ways of constructing reality and shows them *how* to talk and listen to each other. For this reason Cecchin et al. (1993) see family therapy training as “weaning students away from the conviction that what they believe about families is the only correct view (p.133)”. It is not belief or knowing that is the object of irreverence but its rigidity and certainty in a therapeutic dogma or

ideology. The therapist holds their own certainty, knowledge and truth up to scrutiny; it is still utilized but in a way that the ethical relation to the other becomes paramount. Irreverence is a respectful and curious conversation utilizing both instrumental and non-instrumental knowing, where the therapist's questioning of their own prejudices, dogma or truth and its effect on others *is* the therapy.

In the next section I link the concept of *irreverence* in family therapy to the larger landscape of deconstruction in Derrida's play of differences and describe both in terms of this ethical relation to the other.

Derrida's play of differences

“For the whole thrust of deconstruction and its notion of *differance* is to show that such structures are always traces in the play of differences and we do not have access to overarching, trans-historical, transcendental, ontological, universal structures. We are, if there is anything at all to *differance*, always stuck where we are, in the middle of the play of traces, in certain historical (and social, sexual, political, etc.) webs or networks (Caputo, 1997, p.175-6)”.

Jacques Derrida the originator of deconstruction is considered one of the most important philosophers and thinkers of our time, his texts have transformed “the ways in which we think about the nature of language, speech and writing, life and death, culture, ethics, politics, religion, literature and philosophy (Royle, 2003, p.8)”. In family therapy deconstruction is generally understood as a way to unpack and bring out marginalized meanings, alternative

readings or unspoken narratives in a social practice, discourse or text (White, 1992; Pare and Larner, 2004). A central idea is the *play of differences*, which challenges foundational ideas or dominant narratives and introduces a richer and thicker description as an alternative story and meaning in the text. This disrupts metaphysical ‘presence’ as *one* way of interpreting truth, meaning and reality in favor of the *many*. For Derrida like Cecchin et al. (1993) such irreverence is an ethical move: where the question of truth is left open the voice of the other can be accommodated.

Derrida’s play of differences refers to *openness* as the French word for play ‘*jeu*’ suggests; it concerns the extent of ‘give’ in a system or structure as a free movement of thinking, meaning and ideas (Royle, 2003). Where the question of truth, meaning and knowledge is open alternative readings of a text are possible. To have no play is to have a too stable system, a theory, institution or text that is rigid, closed and totalizing. This is a political process of power where one language is dominant and imposed as unquestionable truth. Derrida suggests language works much more playfully; words do not stand-alone to ‘represent’ reality as truth but acquire meaning *in relation to* each other as part of a network or play of differences (Caputo, 1997). Like in a dictionary, the meaning of a word is not absolute but is defined in terms of its ‘traces’ or connections with other words. As Derrida (1978) says: “The presence of an element is always a signifying and substitutive reference inscribed in a system of differences and the movement of a chain (p.294)”.

Meaning is an interpretative act that takes place within a system of differences that Derrida calls *differance*. This word is a play on the double meaning of the French verb *differer* as both ‘to differ’ in a spatial or physical sense and ‘to defer’ with the temporal meaning of ‘to delay’ or ‘put off’. That is, meaning is never final but is always deferred to a language context in a play of differences in time (Critchley, 2002). In a language or text there is a complex web, network or chain of connections where the meaning of a term is inextricably linked to or contains ‘traces’ of its opposite or relational other. For example, decentering only makes sense in relation to a centre or in family therapy non-instrumentality only has meaning in relation to instrumentality; neither term can stand alone. Instead of one *or* the other there is *both/and*, which is what Derrida (1978) calls “a freeplay, that is to say, a field of infinite substitutions in the closure of a finite ensemble (p.292)”.

This is where Derrida’s infamous statement ‘There is nothing outside the text’ derives its significance; it means not that the world *is* textual or contained within a book or language, which is absurd and another ontological statement to boot, but rather that meaning always has a writing or language context. As interpretative beings our experience of the world always occurs within complex and diverse networks or chains of meaning that rebound and reverberates throughout a language. As Caputo (1997) says: “We are always and already, on Derrida’s telling, embedded in various *networks*-social, historical, linguistic, political, sexual networks (the list goes on nowadays to include electronic

networks, worldwide webs)-various horizons or presuppositions, which is what Derrida means by...textuality ...or text (pp.79-80)". In other words there is nothing outside context.

Now this is not unlike a *systemic* understanding of persons in their relational or meaning context and family therapists will be interested to know Derrida was familiar with post-war systemic thinking, including Bateson's work on the double bind and often used the language of systems to explicate the workings of deconstruction (Johnson, 1993). For Derrida as for systemic family therapists there is nothing outside context. The irreverent play of differences in the text is very much a *systemic* play where meaning is always relational and contextual. Meaning is rich or both/and precisely because it has innumerable links and traces elsewhere: "No meaning can be determined out of context, but no context permits saturation (Royle, 2003, p.66)". There is an endless play of language and interpretation that reflects the infinite and unbounded universe we live in. Indeed deconstruction can be seen as an attempt to take such a limitless or systemic context into account (Critchley, 2002).

Irreverence as deconstruction

Deconstruction complicates, disrupts, disturbs or is irreverent towards the marking of rigid oppositions and distinctions between binary terms as final or closed. Now the word 'term' is derived from the French *terme*, which means a limit and the Latin, *terminus*, a boundary (Royle, 2003). What is deconstructed is the notion of an impenetrable boundary between a term and its opposite that

separates them as either/or. As we have seen this is precisely what Cecchin et al. (1993) argued. The irreverence they proposed was not towards instrumentality (I) or non-instrumentality (non-I) as such, but the marking of an inflexible structure or boundary between them. There is I in non-I and non-I in I, which is what *both/and* means. This is irreverence for false idols; there is no one truth that we hold up as the final word, rather in language there is an unbounded play of differences. Instead of a harsh dichotomy of binary terms there is a dance of difference between them. Within one term there is a play of the other: I within non-I, uncertainty within certainty, knowing in not knowing and so on.

One binary term can be seen to enrich or supplement the other, as when a therapist's expertise and knowledge is applied as a *knowing not to know* (Larner, 2000b). The totalizing system that keeps terms diametrically opposed in theory is deconstructed or decentred in practice. As Derrida (1978) said in his famous essay 'Structure, Sign, and Play in the Discourse of the Human Sciences': "The opposition is part of the system, along with the reduction (p.279)". Instead of the hierarchy of this *or* that, I or non-I, first order *or* second order cybernetics, systemic versus narrative, cybernetics versus social construction, narrative versus science or family therapy against all the rest, there is a free play of difference as both/and. This deconstruction is part of the richness and diversity of language and life itself.

Thus all family therapists attempt to be influential and intervene some of the time and stand back and are less strategic and instrumental at other times.

What happens in the practice of therapy cannot be captured or expressed by any one theory or language. Irreverence is a deconstruction that refers to the *play* between these polarized positions. There is no position that is final, rather family therapists are both instrumental and non-instrumental *in response to* the therapist-client system. Indeed as Cecchin et al. (1993) suggest when we are being non-instrumental in the sense of taking responsibility for our own beliefs and actions instead of directing others to do something, we are perhaps being most influential. There is influence in non-influence, the strategic in the non-strategic, I in non-I, power in non-power. This is “a play which is serious, a reverence inside the irreverence” (Larner, 1995).

Irreverence for postmodernism

The deconstructive play of irreverence applies not only to family therapy practice but also operates at the level of theory and institution including the postmodern. This recognizes that the attempt to replace a cybernetic or systemic framework with a postmodern narrative and social constructionist metaphor *is* a modern systemic intervention in the family therapy field. To force a paradigm shift from I to non-I is an instrumental move at the level of meta-theory that reflects a wider paradox or ‘aporia’ (in Derrida’s terms) for postmodernism. To *replace* a modern with a *postmodern* meta-narrative merely perpetuates the violence of the modern where one language or paradigm is imposed on another. This is because the *post-modern* like the modern is defined as a systemic or theoretical *break* with a previous paradigm, era or way of thinking, which is the

import of the prefix 'post'. To substitute I with non-I, systems with narrative, structuralism with post-structuralism, power with non-power etc. puts into *play* the very terms and philosophy one is trying to escape. This is why Derrida has never identified deconstruction as postmodern and why postmodernism in family therapy itself requires deconstructing (Larner, 1994)⁷.

The irreverent play of differences is about the paradox of taking positions: to be non-instrumental is impossible without first being instrumental. And to be non-instrumental assumes a certain instrumentality. What we have is a system of I *and* non-I, where one framework is not replaced but defined in terms of the other. As the non-instrumental therapist par excellence Harlene Anderson (1997) states: "A therapist brings *expertise* in the area of process: a therapist is the *expert* in engaging and participating with a client in a dialogical process of first-person storytelling (p.95, italics mine)". Non-instrumentality has an instrumental face; to set up a non-instrumental conversational space requires the therapist to be instrumental enough to structure it so at a systemic level⁸. Anderson goes on to say: "Not-knowing refers to a therapist's *position*... (p.134, italics mine)". To actively take a decentred position you need to be

⁷ The lesson from deconstruction is we can never get outside or escape the modern; rather deconstruction is an immanent critique that always works from inside or *within* a text or institution (Larner, 2003b).

⁸ Is this an irreverent play of cybernetics in narrative?

centered enough to have influence, which is captured in the narrative therapy stance of being ‘decentered but influential’.

As we have seen this deconstruction is precisely what Cecchin et al’s (1993) notion of irreverence as a play of differences between seemingly contradictory ideas or polarities is about. The binary or structure set by I and non-I is put into play, which means we begin to see one term as essential for the other. Too much I closes off non-I, at the same time enough of I is required to make non-I possible. In Derrida’s terms there is a play of difference between I and non-I as *differance*. As the system of meaning or reference that keeps them apart becomes unstable one term refers to or is deferred to its relational other. As Haar (1992) comments on the play of *differance*: “Play would be the strange place where metaphysical oppositions are produced (p.63)”. Rather than holding to one term of a binary pair as truth there is a process of unlimited play where meaning is deferred to a chain of connections and traces between words and their opposites. Now Cecchin et al (1992) say as much: “To believe too much in non-instrumentality could result in one being trapped, restricted, and unable to act...If a therapist is convinced that by giving up strategizing he can become effective, then he becomes a believer in the *instrument of non-instrumentality* (p.7, italics mine)”.

Deconstruction: more than one language

Contrary to popular understanding Derrida (1995) does not seek to denigrate or destroy modern texts and traditions but to shake them; he greatly respects and

even ‘loves’ what is called the canon of Western literature and philosophy, whether the works of Plato, Freud, Kant or Heidegger. To deconstruct is *not* to be iconoclastic but to discover extra layers of meaning in a text; it doesn’t detract from a prevailing reading but adds a richness of interpretation. There is a thickening of description in the text that shows language and writing to be more complex than first apparent. Deconstruction opens up a space for what has been omitted or suppressed revealing another story in the margins waiting to be told. Like the re-authoring practices of narrative therapy it traces an alternative narrative already embedded *within* a dominant discourse. As Derrida (1997) says it “happens inside; there is a deconstruction at work within Plato’s work, for instance (p.9)”. It is not about negating or replacing an author’s narrative or worldview but understanding the “tensions, the contradictions, the heterogeneity within their own corpus (Derrida, 1997, p.9)”. It is not something we introduce into a text but is already happening there.

This is highly relevant for family therapy as deconstruction is often understood as taking apart a dominant narrative or paradigm and replacing it with an alternative or preferred story. However like Cecchin et al’s (1993) concept of irreverence, what it does is introduce openness, curiosity, play and irreverence into an *existing* system of thinking. Deconstruction involves a “widening of the frames of reference, the loosening of the rigid systems of oppositions, which habitually shape and constrain our understanding of the world (Johnson, 1997, p. 53)”. Instead of pitting one theory, paradigm, term or

idea *against* another, such as the modern *versus* postmodern, it introduces both/and diversity into the narratives we use to make sense of the world. What is deconstructed is precisely the power relation whereby one discourse or language comes to dominate another as part of the socio-politics of theory and institution. As a matter of ethics it is why Derrida (1995) has defined deconstruction as *more than one language*.

This is the very idea of a *respectful irreverence* towards theory that Cecchin et al. (1993) expound. These authors demonstrate a ‘deep respect’ both for the tradition of instrumentality in family therapy (espoused by pioneers in the field such as Haley and Minuchin) *and* for postmodern champions of non-instrumentality (like Harry Goolishian and Lyn Hoffman). Instead of siding with one *or* the other, irreverence concerns the play of differences between them, a stance that accommodates both perspectives despite the contradiction or theory tension. As we have seen for postmodernists to say ‘I’ should be replaced by ‘non-I’ is itself a move of modern instrumental power that marginalizes those who believe in the value of structural or strategic interventions in family therapy, as well as dismissing psychiatry and psychology colleagues with a more linear understanding of therapy (Larner, 1994; 2003a).

The ethical play of irreverence

Deconstruction is a celebration of difference that makes ethical relation to the other possible. It opens up a hospitable space for the marginalized voice to be heard and is entirely about the ethical and justice in relating to others. As

Derrida (1997) states: “ Of course, deconstruction-that has been its strategy up to now-insisted not on multiplicity for itself but on the heterogeneity, the difference, the disassociation, which is absolutely necessary for the *relation to the other* (p.13, italics mine)”. One deconstructs *for* the other and here Derrida (1999) assimilates the ethical philosophy of his contemporary Emmanuel Levinas in giving priority to the singularity or uniqueness of a relational encounter with another person. For Levinas what is *Said* in the form of objectifying theory and knowledge takes second place to the ethical *Saying* as a face-to-face relationship and encounter with another human being (Larner, 2004b). For Derrida following Levinas this is the challenge of *hospitality*: to suspend or deconstruct one’s theory and knowledge in order to speak the language of the other: “As Levinas says from another point of view, language *is* hospitality (Derrida, 2000, p.135)”. To begin to speak the language of the other is a gesture of welcome, understanding and relationship.

The ethical in deconstruction concerns not a system of principles but the cultivation of a sense of responsibility and hospitality towards another person that makes relationship and dialogue possible (Caputo, 2003). In deconstructing my own belief or language system, by being irreverent towards the theory or language I speak as a therapist, I become open to how others think, believe and speak. This creates a relational space for the other to be *other*, that is, different from me and from my image, idea, projection, thought, hypothesis, formulation or theory of them. As Cecchin et al. (1994) say the one way screen in family

therapy primarily becomes a mirror for therapists to deconstruct *their* issues and prejudices about how they see another person or family: “This kind of intellectual disrobing requires a deeply held conviction (bias) that *any* idea has an equal right and dignity in a conversation. How this is done requires time and practice, a sense of playfulness, irreverence, and reverence for the dignity and right of colleagues to hold different views (p.28)”.

The ethical play of irreverence is the willingness to put the other *first* before one’s theory, model, idea or knowledge about the world. It is concerned less with disbanding theory and techniques in family therapy and more with *how* therapists approach the relational other, by being open, transparent, curious or humorous. From irreverence the ethical follows: if no one discourse or theory is *true* there can be openness and respect towards what others believe and say. When therapists take responsibility for deconstructing their own theory and prejudices they create the very conditions for therapy. Cultivating an ethic of hospitality in family therapy, “we feel the desire to engage, to be curious, reflective and interested in how the other speaks and makes meaning, to learn their language while speaking our own (Larner, 2003a, p.212)”. The ethical play of irreverence is a relational engagement and wider conversation of understanding with clients and colleagues that defines systemic family therapy.

Conclusion: the first family therapist?

“Have we reached a position where we are ready to dare to question the unquestionable-even at risk of deconstructing the entire family therapy movement? (Cecchin et. al.1994, p.60)”.

The implication of irreverence and deconstruction as *more than one language* is not that we abandon theory but our prejudices and dogmas and embrace diverse ways of thinking family therapy. This includes the systemic metaphor that founded the profession and still informs it, scientific and evidence-based perspectives, narrative and conversational approaches of the postmodern era, the ethical in deconstruction, irreverence and other revitalizing metaphors still to come. Family therapists can benefit from being multilingual or living in several theory languages at once (Burck, 2004). Instead of there being discrete and competing paradigms that break with, replace and *post* the other, in one we are likely to find the irreverent play of the other, such as I in non-I, the systemic in narrative or the modern in the postmodern as *paramodern* (Larner, 1994). As Cecchin et al (1994) say: “New metaphors always play off of the old, the so-called, truths of the dominant theories of the moment (p.59)”. This preserves or conserves the traditions and foundations of family therapy even as they are deconstructed.

In this paper I have argued the field is deconstructing itself along the lines of Cecchin et al’s (1993) irreverence, which increasingly defines best practice in family therapy today. A deconstructed family therapy is instrumental, scientific,

evidence-based, interventionist and integrates biological and cognitive treatments in family systems work. This keeps it accountable, effective and viable in the science of therapies. At the same time modern discourses of pathology are enriched by postmodern narrative and social constructionist approaches (Larner, 2003a). The irreverent family therapist is pragmatic, practice-based, integrative and *open* towards different ways of thinking the work. He or she takes responsibility for deconstructing their own beliefs and prejudices in putting the other *before* theory and technique. The ethical play of irreverence is a stance of openness and curiosity that engages the other in a wider conversation of meaning and understanding, which *is* family therapy today.

Finally Cecchin et al (1994) tell the story of ‘the last family therapist’, unable to exit the field and retire gracefully, as meetings, conferences, workshops, the writing and reading of books and articles and so on just keep going on. Yet what they herald is also the *first* family therapist still becoming in all of us. Deconstructing the theory and language of family therapy –the jargon, the solutions, the discourse or talk of the talk, the selling of the profession etc. is a process of beginning the work *anew* with an irreverent spark of curiosity, hospitality and ‘dignity’. As family therapists we are *always* arriving in the sense of deconstructing our prejudices, learning more than one language and enacting responsibility in therapy.

Irreverence is an endless play of difference as the ethical that is always beginning. As Derrida (1997) notes deconstruction is what is *to come*: “The first and last, the constant word in deconstruction is come, *viens* (Caputo, 1997, p.156)”. This is a welcoming of the singular, unexpected, incomprehensible and unpredictable event of the *other*, which is the irreverent and ethical encounter itself. Despite physically passing to their *other* the ideas of Gianfranco Cecchin and Jacques Derrida are most alive. A final testimony: “I am the only one who can testify to my death-on the condition that I survive it (Derrida, 1998, p.45)”.

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Chapter 5: Levinas: Therapy as Discourse Ethics⁹

Introducing Levinas

In this chapter I introduce the ethical philosophy of Levinas and consider its implications for therapy as a discourse ethics, providing practice examples along the way. Emmanuel Levinas who died in 1995 is one of the most significant Continental philosophers of our time (Critchley and Bernasconi, 2002). Like French contemporary Jacques Derrida (1999) his thinking has influenced diverse fields of poststructuralist study including more recently psychology and therapy (Gantt and Williams, 2002). Levinas's unique contribution is the notion that first and foremost we are ethical beings. This *ethics first* philosophy was to some extent a personal response to the horrors of the Second World War and the holocaust. As Levinas (1995) says: "To overcome the ethical is the beginning of all violence. To acknowledge this is very important after the events of 1933 to 1945" (p.58).

Though for Levinas the ethical is overridden not just by physical violence but by a Western philosophy of being, which effaces persons by reducing them to concepts like reason or intentionality. War and philosophy can

⁹ This chapter was published as a book chapter in Strong, T. and Pare, D. (2004). *Furthering Talk: Advances in the Discursive Therapies*. Kluwer Academic/Plenum Publishers: New York.

have similar effects, indeed the former is “fixed in the concept of totality, which dominates Western philosophy” (Levinas, 1969, p.21). To reduce the lived experience of another person to finite categories of our understanding is a totalizing act that does them violence through language. We no longer see the *person* but an idea or representation of their being as defined by cultural, gender, physical, racial, psychological attributes, and so on. Whether you are a Nazi or a philosopher (in the case of Heidegger disturbingly both), to reduce the other to an idea or concept is dehumanizing and compromises their difference and freedom.

The Saying and the Said

A person is not an abstract concept, a biological entity or cognitive being but someone we speak *to* as part of a relational act; by placing them under a category or label we step outside the relationship and cease to participate in a conversation. Acting as outside observers we impose a totalizing meaning or rule of the same, an objective way of talking and thinking *about* a person, that Levinas calls the *Said*. In simplistic terms the Said is the objective content of what we say, the ideas, meanings and observations we want to communicate. This form of discourse is totalizing and violent when it forces meaning on a person ignoring what is uniquely different about them. It deploys what Martin Buber famously called ‘I-It knowledge’ rather than ‘I-Thou dialogue’. This treats “the other person as a thing under my power” seizing the relationship in a total act of comprehension (Levinas, 1993, p.40).

By contrast Saying is the relational context for speaking and communicating *with* another person, the here and now dialogic encounter with another human being. The focus is less what is said and more the *how* or process of saying it. The intent is vocative: to engage others in dialogue rather than use language in a way that treats them as objects. Here discourse is an ethical process of making space for the voice of the other in dialogue and conversation (1). The self is defined not as I or It but as *thou* where language breaks through as “the very bursting forth of thought dialogically coming out of itself” (Levinas, 1993, p.40).

Yet for Levinas both the Saying and Said are needed: “Without the Said there is no philosophy and, more importantly, no society, justice, judgement or ethics either” (Davis, 1996, p.79). In ethical relation, knowledge, technology and power that define the Said are still there, but there *for* the other. I will comment on this later in relation to how discursive therapists use language and knowledge in therapy.

Facing the other

The ethical relation celebrates a person’s difference or otherness or as Critchley and Bernasconi (2002) say: “Ethics is the location of a point of otherness...that cannot be reduced to the same” (p.15). What contributes most to another person being different is the fact they have a body and especially a face, which establishes they are completely *Other* from me. This is something we experience or *feel*: “The other’s otherness is what makes me feel and makes me

think what I feel “(Diprose, 2002, p.137). Ethical relation begins with my experience of another person as physically separate from and yet proximate to me; this is a spiritual-like awareness of the singularity and separateness of human beings (2).

For Levinas what is most Other about a person is their face as a powerful expression of personhood and a focal point for interpersonal communication. Here Critchley and Bernasconi (2002) note: “The central task of Levinas’s work, in his words, is the attempt to describe a relation with the other person that cannot be reduced to comprehension. He finds this in what he famously calls the ‘face to face’ relation (p.8)”. Infant attachment research shows mutual gazing at the face is an essential component of bonding between parent and baby. Though for Levinas the face is my whole experience or encounter with another person in so far as they transcend the knowledge or concept I have of them: “The way in which the other presents himself, exceeding *the idea of the other in me*, we here name face” (Levinas in Critchley and Bernasconi, p.15). What the face speaks to is our *failure* to comprehend the other, it is “an epiphany that resists conceptual grasp” (Wyschogrod, 2002, p.195). A person has a body and face beyond my concept or understanding and cannot be captured within a prescribed system of meaning and language.

Discourse ethics

In other words when we engage in discourse persons have a singular and individual presence that defines them as other and not me, a body and face that

allows relationship and conversation to be possible. Because persons already have a meaning we have to be mindful about using language to totalize their experience: “The neighbour is precisely what has a meaning *immediately*, before one ascribes one to him” (Levinas, 1987, p.119). This is why for Levinas (1995) the first move of discourse is always ethical: “Language is fraternity, and thus a responsibility for the other (p.123)”. In the physical presence of another there is a welcoming and reaching out, a gesture that acknowledges the person as other.

This is what Levinas calls the ‘place offered to the stranger’, which provides refuge or hospitality to a fellow human being: “the welcome of the other or of the face as neighbor and as stranger, as neighbor *insofar as* he is a stranger, man, and brother” (Derrida, 1999, p.68). Discourse begins with the welcoming of the other as separate or different from me. The other is my neighbor with a body that requires nourishment and a face that speaks and calls for a welcome. Ethics is a welcoming of the stranger as physically separated or other, and from such fraternity dialogue or discourse begins.

The self is ethical

Personhood begins *with* the neighbor; persons are not disconnected thinking beings but in dialogue with and responsible *for* each other. The self is not structured as *I* but as *you I* or persons in dialogue and relationship; self is defined in the process of reaching out to and welcoming the other in language, conversation and discourse. Persons are constituted by responsibility and ethics:

“The word *I* means *here I am*, answering for everything and for everyone
“(Levinas quoted in Derrida, 1999, p.55). What comes first is not self but the
other, an emptying out or giving up of oneself that Levinas (1987) calls an
“ethical event of “expiation for another”” (p.124).

Ethics before discourse

Ethics is presupposed by discourse or as Levinas says: “This responsibility is
prior to dialogue, to the exchange of questions and answers... (quoted in
Derrida, 1999, pp.56-7)”. What makes discourse possible is first of all an ethical
reaching out to the other, who is put before oneself. This simple humility or
interpersonal generosity as an interest in a person’s otherness, as in a cultural,
ethnic or gender sense, provides the conditions for discourse as a mutual
exchange between persons. For Levinas ethics as a responsibility towards the
other is a condition of discourse. From ethics, discourse follows. Or as Diprose
(2002) comments on Levinas: “And this giving of one’s self-possession
amounts to the opening of myself beyond myself through discourse,
conversation, language” (p.140).

The talking or discursive person is first of all ethical and to be
ethical is to acknowledge the physical presence of the other particularly their
face. Before I speak, I welcome the other. Before language and subjectivity is
ethics: “To approach the Other in discourse is to welcome...” (Levinas, quoted
by Derrida, 1999, p.18). Before I, before the word, comes the other as a Saying
between us. *I other*. The other constitutes my self as a communication in

gestures or words. While persons are discursive beings, discourse depends first of all on ethics (3). Because the self is first of all ethical, welcoming the other is always the starting point for discourse. This is what Derrida (1999) following Levinas calls an ethic of hospitality, where “discourse, justice, ethical uprightness have to do first of all with *welcoming* (p.35)”.

Therapy as discourse ethics

What does this mean for a discursive therapy? An ethical encounter is not merely discursive but presupposes a physical and non-verbal experience of the other person. Before anything can be said or done the therapist is first of all *there* for the other, like a mother’s face is there for her infant before words are spoken. This form of relating *takes in* freely, it is unconditional; it is the non-discursive condition of the discursive, the bridging of a chasm between two persons through what is unsaid and cannot necessarily be put into words, what Frosh (2001) refers to as the *unsayable* in therapy. Cohen (2002) describes this pre-discursive sensibility using Levinas’s concept of ‘maternal psyche’: “The other morally encountered is “in-me” as if the other were literally in my body, the other’s pain my pain, the other’s suffering my suffering “(p.46). Here the self is defined ethically as an obligation to the other as if they were present *in* me.

Discourse in therapy begins with this pre-discursive welcoming or taking in of the other. The therapist knows and thinks *with* the person in a way that is ethically and dialogically responsive, more than empathy this being-in-

the other defines what it is to be human. First there is an orientation to the person as different followed by a desire to learn their language or culture and participate in discourse. Here the therapist's use of a professional language is tentative and depends on first learning and becoming fluent in the language of the other, such as the descriptive terms and metaphors they use. What clients say is put *before* what therapists say and do; their words and meaning are taken in by the therapist. This allows the possibility of a reciprocal gesture, where the client is open to taking in what therapists have to say and offer. This dialogic process is a face-to-face exchange and sharing of meaning, a flow of conversation between persons that allows a common language of understanding to evolve. Whatever professional or client languages are spoken this mutual welcoming is what defines therapy as a discourse ethics.

Practice example 1 (The following practice examples are composites of dialogue with real clients using fictional names).

Jay is a highly intellectually gifted 14-year-old boy referred because of his chronic negativity, self-denigration, oppositional behavior, social isolation, academic underachievement and almost total non-compliance with class or home-work, all issues of several years standing. In the initial family interview I asked why they had come to see me.

Jay: *I'm insane; my parents brought me here to stop me from being insane.*

I asked Jay what might lead them to think that.

Jay: *They're stupid.*

Mother: *It's complex. He's not coping at school, reluctant to engage in lessons, unwilling to learn and not inviting people over.*

Jay: *I have no friends mum.*

Mother: *He's not pursuing sport.*

Jay: *All this means I'm lazy.*

Mother: *And worse of all, he has hurt himself scratching his arm on a few occasions.*

Father: *With a craft knife.*

Jay: *I'm high on the insanity list.*

Mother: *He is extremely bright but very unhappy in the school environment. He's happy being at home if we're not talking about school.*

Jay: *If it involves thought or energy.*

At this point I asked what the father thought.

Father: *I am a depressive personality. The systems of the world don't suit us.*

Mother: *Jay is also a depressive.*

Jay: *The world is a hole.*

A welcoming stance

Jay spoke this with an extreme sense of sarcasm and irony and was particularly scornful about counseling. Later I found out the father had a long history of severe depression involving medication and like Jay didn't take kindly to school or therapists. In this first interview I strongly *felt* both were extremely sensitive about labels like sane/insane, as evident from the way they continually

introduced them in the conversation. Thus an essential part of welcoming this family was not to apply them; the challenge for me was *not* to be a therapist, to intervene by not intervening, to do therapy without doing therapy. In Levinasian terms this path *between* knowing and not knowing leaves meaning open and puts the person first before the language of therapy.

At the end of the session I told the family in the face of such complexity (as the mother termed it), I could not presume to offer a solution where none had been found, but we could talk more if they were willing. After one year we still meet together weekly for family therapy, a multisystemic approach that includes regular meetings with the school and Jay's closest friend. Jay is now significantly less depressed and oppositional, making friends, showing more interest in his work and participating at school. In discussing these changes the parents confirmed my ethical stance of not applying labels was crucial.

Here a relational stance of welcoming Jay and his family as other *is* the therapy. A therapist can be reflective or interpretive in the session and even suggest strategies for change but the crux is *how* this is done? In ethical relationship the therapist's voice is one among others. There is a collaborative sharing of ideas, insights, thinking and understanding, where meaning is not final or total but there is respect for its complexity. In the midst of a never ending riposte of words between Jay and his parents, I was given space to talk and contribute my own thoughts and reflections. For example, in one session I interpreted intense hostility between Jay and his mother in terms of attachment

and they were prepared to listen because I had first listened to them. From my welcome I was welcomed, which meant whatever therapy provided was more likely to be accommodated. Later the mother was astounded when Jay actually requested to speak to me about his school situation.

The relation to the other

In these terms, therapy is first of all the enactment of a person-to-person relationship. Whatever a therapist says or does, what matters most is how he or she *is* towards the other. The therapist is hostage or host to the other welcoming him or her in a spirit of hospitality. This ethic is the substratum of therapy. Therapy is not a mere technology imposing a language of expertise and knowledge but enacts a relational ethics. This is a gesture of hospitality, a welcoming of the other to a place where dialogue as a speaking between persons can occur. Whatever happens after that, in the form of therapeutic techniques, strategies or approaches is secondary to face to face Saying and dialogue.

This accords with outcome research showing what contributes most to change is not therapeutic technique or model but “common factors” across all approaches, like the therapeutic relationship and whether the therapist is perceived as empathic, caring and compassionate (Miller and Duncan, 1998; Lerner, 2001). Change is not the result of a detached instrumental knowledge but emerges from the Saying between persons in the room. The language of therapy is not forced on others but a welcoming vehicle for discursive sharing.

By taking care not to impose a preferred discourse from a position of power, the therapist helps persons to speak and construct their own language of change.

Here therapy enacts a process of relational discourse; a shared language of understanding that allows agreement about the purpose of therapy, where there is less risk of a client resisting a therapist's language and interventions.

A thinking space

Through ethics therapy becomes a talking or discursive space in which thinking is possible, where client and therapist learn to think and reflect together. The first step for the therapist is to be welcoming to what others say. Here thinking is not private but occurs in the presence of others, but it is also to be *disturbed* by the other. It is because the other is other and not me that I am obliged to respond and enter discourse. The other disturbs my self-sufficiency, forcing a relationship beyond myself through discourse. This disruption of my autonomy, which brings me into relation with others, *is* ethics. By welcoming what is strange and other my usual schemas are disrupted and new thinking and learning is possible. Thus with Jay and his family I was forced to confront my own values and beliefs about what therapy can be or achieve. If I merely applied labels (like oppositional–defiant disorder) and corresponding treatment, they would have refused to participate (4). If I was to help I had to encounter them face-to-face and in turn they were invited by my presence and words to reflect upon possibilities for change.

This ethical relation is distinct from a code of ethics all therapists are obliged to follow, like confidentiality and respecting personal boundaries (Sullivan, 2002). Over and above a professional ethics it is present at every interactive moment as a welcoming and speaking *to* the other. Whatever else is said or done in therapy the ethical relation prefigures *how* persons are to speak to one another. Here therapists model an ethical process, where persons are defined by their responsibility in discourse with each other.

Practice example 2

Kino is a 13 year old boy with mild cerebral palsy, chronic encopresis, enuresis and lack of self-care skills in dressing and toileting. His physical disabilities are not severe enough to account for these difficulties; rather he refuses to care for himself. At school he is unable to learn or complete schoolwork. Kino presented as an affable, talkative lad adopting an ‘I’m okay’ posture saying he enjoyed school with no problems in his academic, social, personal or family life. The message from the parents was the exact opposite; they were exhausted by a daily regime that included putting him on the toilet to prevent soiling *and* wiping his bottom, which he refused to do. This latter issue became the focus of family therapy and after several interviews I shared my thinking about Kino’s predicament.

In reflecting with the family I suspected he was reluctant to grow up (which he freely admitted) and connected this life choice to parental anxiety about his disability from an early age. A wider systemic issue was the mother’s

role as a caregiver for her aged parents in the family home. I suggested Kino's refrain was opposite to the steam train *Puffing Billy* in the children's book, who struggling up the mountain repeats: "I think I can", I think I can". For Kino it was: "I can't therefore I won't". Yet like all adolescents Kino wished to be seen as normal and cool, particularly by peers and in this sense he was Janus-faced, with one face looking back to the safety and security of childhood and the other ahead. Nonetheless I said I could understand why Kino may not want to grow up and recounted a personal memory of my own soiling incident in early childhood, where like Kino I experienced the pleasure of sitting in one's pool oblivious to the world. Here the therapist encountered Kino face to face; in struggling with his personal dilemma about growing up, metaphorically speaking, I was in him and he was in me.

Next I asked the family: "What might entice a boy of Kino's age to grow up?" Kino replied he would 'love' (the first expression of enthusiasm I heard) to be five years older so he could access advanced technology like computer games. An animated relational exchange between Kino and his father followed that was different and surprising, particularly as I had not sensed a strong attachment between them. I asked what else being grown up might mean and to the astonishment of all Kino said in the future he fully expected to wipe his own bottom. The mother said this was the first time she had *ever* heard Kino talk in such a mature, self-aware and responsible manner. I asked whether technology might be accessible for Kino sooner rather than later and suggested

a behavioral reward system using star charts for soiling, as the family had used them under previous therapists. For four months Kino has not soiled his pants and has wiped his bottom every day.

How do we explain such change? At one level it can be seen in terms of family therapy combined with behavioral techniques (Carr, 2000) in a systemic process that explored the meaning of the problem; at another it enacted an ethical relationship pivotal to the change process. The *welcome* I accorded to Kino and his family allowed my reflections and a shared Saying about growing up in his personal and family story. Here the sharing of my own personal experience and a book about steam trains and other possibilities gently involved Kino in a discourse of change where he became more responsible to others and for himself.

Modern/postmodern discourse in therapy

“Of course we inhabit an ontological world of technological mastery and political self-preservation. Indeed without these political and technological structures of organization we would not be able to feed mankind. This is the great paradox of human existence: we must use the ontological for the sake of the other, to ensure the survival of the other we must resort to the technical-political systems of means and ends... We have no option but to employ the language and concepts of Greek philosophy even in our attempts to go beyond them” (Levinas, 1984, p.64).

In this section I discuss some implications of Levinas and discourse ethics for the modernist/ postmodernist debate in therapy. I assume what Levinas here calls the *ontological* is manifest in a totalizing use of language in modern psychology and therapy today, which assumes an objective knowledge of psychological being. Otherwise known as the scientist-practitioner model or evidence-based practice in therapy, personal experience is diagnosed as individual pathology and treated in standard cost-effective ways, like biological psychiatry or cognitive therapy. Postmodern or discursive therapists deconstruct this paradigm in favor of narrative, social constructionist and relational understanding of persons in the world (Gergen, 1999). They critique the neglect of personal and relational context in modern therapy and emphasize the role of culture, gender, politics and spirituality in psychological well-being (Larner, 2001). Modern therapists in turn debunk non-evidence-based psychotherapy as woolly, unsubstantiated and ineffective.

The postmodern fallacy

Now to use Levinas to support postmodern *as opposed to* modern therapy would be misleading as the above quote suggests. This commits what I call the postmodern fallacy, which paradoxically sets up a violent opposition or forced duality between narrative *and* science, the modern *or* postmodern. However this institutional or foundational move repeats the very totalizing that defines modernity; it is the same old politics of exclusivity where therapists belonging to one school of thought totalize and dismiss another (Larner, 2003). A science

of therapy needs ethics to give it a human face, but it is not simply a matter of one replacing the other, one *or* the other, but a more complex situation of *both/and*.

As Levinas (1984) says ontology is “necessary but not enough (p.64)”, we may not be able to escape its language but we can introduce the ethical relation into it. Here the language of ethics and being co-exist (albeit uneasily) as the *ontological for the sake of the other*, a paradox that Levinas (1984) sees as providing a “golden opportunity for Western philosophy to open itself to the dimensions of otherness and transcendence beyond Being “(p.64).

Both science and ethics

Levinas notes if people are starving ethical relations are no use to anyone; without a technology of being there would be no persons or ethics at all.

Likewise in therapy an ethical relation to the other behooves us to address psychological pain and suffering using the best modern technological means possible. For example, if a client is seriously depressed or psychotic, best practice such as hospitalization or medication may be life-saving. Ethical therapists have pragmatic concerns to apply what works best in therapy while acknowledging outcome research that establishes the therapist’s relational stance as central; as my practice examples illustrate, what we do in therapy may be less relevant than *how* we do it.

Therapy for the other

Just as for Levinas the Saying and Said go together, in therapy there is a two way relationship between ethics and science or discourse and model, so that one enriches the other. Technology in therapy can be integrated as part of “the *thou* to describe a human encounter” (Levinas, 1963, p.359). Here the challenge is how to apply knowledge and technology in an ethically sensitive way, that is, where what therapists say and do is in the service of the other. In ethical relation the person comes first before theory, knowledge and technique; these take second place to the person, the therapeutic narrative and the therapy relationship.

The various theories and techniques of modern psychology and therapy are still there, but there *for the other* (Williams and Gantt, 2002). Following Derrida I call this both/and stance an ethic of hospitality (Larner, in press), another name for it is discursive wisdom (Pare, 2002) or collaborative influence (Strong, 2000), which respects all languages and discourses in psychology and therapy (Paré and Larner, in press).

Conversational Partner (Tom Strong)

Tom: Lately I’ve been thinking of discourse as a conversational or conceptual immune system – a conditional way of being in the world or in the language you’ve shared here, it is a privileging of particular versions of the Said over the Saying. Extending this concept, it seems that some forms of 'the Said' serve us in both protective and growth-oriented ways, like particular traditions do. Many constructionists use the language of "resources" when they speak about these

forms of the 'Said' (stories, concepts, discourses). How might Levinas have advocated for a therapy that combines the resourcefulness of some forms of the 'Said' AND therapist/client involvement in the 'Saying' of therapeutic conversation?"

Glenn: "I like your metaphor of discourse as a kind of conceptual immune system, which introduces the language of biology and the body into discursive thinking, which as you know has been neglected at least within family therapy and social constructionist circles. (Flaskas, 2002a). Discourse is not everything and Levinas puts great emphasis on body and face, the physical presence of the person before me as *other* who is experienced in the Saying between us. Now whatever is Said becomes a Saying or is translated into relational discourse and in this sense Levinas opens up the whole field of therapeutic knowledge to be available for the discursive therapist; we can utilize whatever therapy training and knowledge we have, which is there *for* the other. And in this day and age it would be irresponsible for therapists *not* to utilize particular resources of the Said, for example, best practice interventions for victims of trauma, violence, depression, self-harm, anxiety and so on. For example, a suicidal young person first requires protection and safety for their person; discourse can follow later (Larner, in press).

What makes the difference for discourse ethics is *how* therapeutic knowledge is used, whether I put *thou* as ethical relation to the other first? It is not that Levinas denies knowledge; rather It proceeds from ethics. Because we fail in

our attempt to completely know the other, a more humble way of knowing is required. As an ethical therapist I draw upon the training and knowledge of my discipline in a way that opens up what I know to not knowing or the otherness of the other. This means the resources of the Said, the technology and knowledge of therapy, become integrated as Saying in therapy conversation.

Practice example 3

A 14 year-old boy was referred to me because of chronic stealing and lying in the home. He had been adopted by an Australian family at the age of 5 years after spending his infancy and preschool years in an orphanage in Vietnam. Now while his behavior falls under psychological categories like conduct and reactive attachment disorder, to stop there tells us little, particularly as outcome research on treatment of these disorders is primitive(Carr, 2000). As I hear this boy's personal narrative I realize his symptoms relate not only to a serious disruption of early attachment but also to an extreme trauma and deprivation, where stealing and lying in the orphanage was essential to survival. In conversation with the adoptive family further systemic and cultural meanings emerge. The parent's have high Christian moral standards and judge stealing and lying as the most shameful behavior possible and this has led them to question their own parenting capacity and to doubt the whole adoptive venture. This has significant implications for ongoing attachment issues as well.

Knowing not to know

Such reflection opens up the possibility of a rich *integrative* approach to therapy that includes psycho-education concerning attachment and trauma, behavioral management of stealing, family therapy, individual therapy and discussion of cultural and ethnic differences (Larner, in press). The ethical relation provides a link between these various languages. Here modern and postmodern therapy sit together *for* the other, so neuropsychology, trauma and infant attachment research, issues of cross-cultural adoption and other psychological knowledges can be treated with the fascination and respect they deserve. Like all therapists, discursive therapists have a professional responsibility to offer the wisdom of what is known and works, the difference is applying it in a non-totalizing way. Ethical therapists do not relinquish knowledge and power but use it for justice, to empower others (Larner, 1995).

The person is more than the description but this does not mean I cannot have descriptions; rather there is room for them to *fail* in comprehending another person. In this stance of not knowing therapists still know but what is more important is *how* they know, in a way responsive to the person. Ethical relation involves a position of not knowing *and* knowing, a therapy stance I call ‘knowing not to know’ (Larner, 2000). Therapeutic skills and professional knowledge as the Said are utilized *for* the other as Saying.

Here the therapist knows *when* to know and when to let the client do the knowing. There is interplay between different ways of knowing that allows a mutual relationship of influence to evolve in the conversation. At one point the

client knows, then the therapist knows or both can know at the same time, but what is important is for each to be willing to hold their knowing humbly or in abeyance long enough to speak with each other. In sharing therapeutic knowing in a non-totalizing way the therapist demonstrates ethics or how to be there *for* the other.

This process of curious, open, transparent, flexible and creative enquiry is an interchange between knowing and not knowing that Rober (2002) calls 'constructive hypothesizing'. Here knowing is the thinking of therapists in the presence of others, bursting forth as dialogue and language. Thus Kino's story above elicited my own experience and in response Kino could share his knowing and become more responsible in the process. The inner thoughts therapists have in response to others becomes outer talk as a Saying in the session; expertise and knowing is shared and the client is encouraged to do likewise. With Kino I introduced my hypothesis into the family conversation as a tentative attempt to think in the presence of other. This immediate face-to-face response to another person in discourse is ethics. My encounter with Kino helped him to be more responsible for self and others. Though as Levinas might say in ethical relation I do not think or know so much as tremble. It is the saying of the other in me.

The paramodern

This integration between knowing and not-knowing bridges the usual dichotomy between the modern and postmodern, a both/and positioning I call

paramodern (Larner, 1994a). This addresses the fact that discursive therapists often work within modern mental health organizations that demand accountable practice as a condition of funding or employment (Larner, 2003). Thus as a postmodern social constructionist or narrative therapist I am professionally required to work with colleagues *within* the orbit of modern therapy discourses such as biological psychiatry and cognitive therapy. Here the deconstructive challenge is how to be ethical *and* apply evidence-based therapy as technology, which enhances best practice for all. Ethical therapists can speak a particular therapeutic language and apply techniques while emphasizing the therapeutic relationship and what is unique and different about a personal narrative (Larner, in press).

Therapy as Other

In other words, there is a technology of being *and* a language of the ethical that opens it up to transcendence and the Other; both sit together despite the tension. Science is not discarded; rather transcendence enters of its own accord. Often in real life therapy the finely tuned package of therapists is disturbed by otherness, the person doesn't quite fit the formula and the cookbook solution doesn't apply. Therapy becomes an extra-ordinary experience; there is a break in the ordinary and everyday application of therapeutic knowledge or expertise: "The otherness or strangeness of the other manifests itself as the extra-ordinary par excellence: not as something given or intended, but as a certain disquietude, as a

derangement which puts us out of our common tracks (Waldenfels, 2002, p.63)”).

As Levinas would describe it, the ethical relation is what transcends or breaks into any therapy as completely *Other*. The application of an approach like cognitive or family therapy is interrupted and we come up against the person beyond the therapist’s grasp or understanding. The therapist is brought into a strange relationship with the Other where another way forward is possible. Sometimes change can appear out of the blue in the form of random yet mysteriously fated events I call ‘miracles’ or ‘narratives of destiny’ (Larner, 1994b, 1998).

Conversational Partner (Peter Rober)

Peter: In your chapter you reflect as a therapist on philosophical sources and inspirations. This is what family therapists have been doing the last 30 years. What strikes me most, however, is the importance of *ethics* in your chapter, and the (almost) absence of epistemological questions. This is rather uncommon in family therapy literature. You write: "In these terms therapy is first of all the enactment of a person-to-person relationship. Whatever a therapist says or does, what matters most is how she *is* towards the other." Indeed, sometimes we forget that therapy is, in the first place, a meeting of two (or more) mortal human beings trying to make sense out of their lives. While reading your chapter I started to wonder why family therapist have put so much energy into

discussing epistemological questions and so little with ethical questions. Maybe you have thoughts on that?

Glenn: Thanks for your reflections which I briefly speak to below in order. As you say family therapy has put epistemology before ethics, which I suspect reflected the modern philosophical impulse in which the discipline was founded by Bateson and his colleagues in postwar systems thinking. Family therapists then began to appreciate the aesthetic basis of knowledge, instead of acting upon family systems it was enough to be *with* persons in a stance of curiosity and systemic wisdom. With the narrative metaphor we began to appreciate stories and locate therapy in a wider contextual, cultural and political ethos. The ground was set for ethics and social justice to become paramount: we know because we are in relation *to* and responsible *for* the other. So I see family therapy as having gradually moved towards an ethical epistemology, which is why Levinas may be so relevant now. Of course my argument is we need both knowledge *and* ethics.

Peter: Another thing that fascinated me is your idea that thinking occurs in the presence of others, but that it also is being disturbed by the other's difference. In my words, I would talk about *surprise*: what surprises me in the contact I have with my clients makes me think and try to understand. I often use this surprise as the starting point of a conversation and a collaborative search for understanding. It's nice to read that you call this surprise, this disruption of my autonomy, *ethics*.

Glenn: Being surprised or disturbed by the other goes along with an ethical relation as a face-to-face encounter with another person. This exposes therapists to a point of vulnerability and fragility both within themselves and others. The protective shell of the therapist's knowing is intimately and experientially informed by the other; in other words you *feel* their suffering, which is disturbing, but this being *with* the other expands possibilities for change. In your chapter Elly putting a needle into her mother was surprising to you and this 'play' invited you to participate more fully in the family experience. From your disturbance or surprise new thinking and reflection followed. A similar process happened with Kino where I was disturbed enough to think my own soiling story and this self-disclosure opened up a wider conversation with the family.

Peter: Thirdly, what I found less surprising (since I read other publications of yours), but very important is your struggle with the modernist/postmodernist dualism. Especially your warning that postmodernism sometimes totalizes (when it presents itself as the better approach, and tries to replace modernism), and that we need a both/and position in this debate. Also in other discussions you search for a both/and position. For instance: your view on power as inevitable, but also as an ethical responsibility: 'how can I use my power and expertise humbly, respectfully, and in the service of the client's wellbeing,' What I like about this is that you have a very ethical view of the therapist, but not a restrictive view. In your view of therapy there is room for family therapy,

psycho-education, attachment theory, play therapy, and so, as long as they are used in a non-violent, non-totalizing way.

Glenn: Nicely put and here I consider myself a pragmatist much like my family therapist colleague in Australia, Carmel Flaskas (2002a, b). As a practitioner for nearly thirty years I find many therapeutic approaches fascinating and valuable or as I have said previously, change whether at the level of persons or the universe is a multi-faceted, complex and mysterious affair (Larner, 1994b).

Here modern and scientific approaches to therapy like cognitive therapy, neuropsychology research or biological psychiatry have a role to play. I want to see the therapy field as a whole becoming more discursive and ethical, I believe this will happen and is what this book offers. Following Levinas the overriding question for me is *how* knowledge can be ethically situated or used *for* the other.

Conclusion

One has to be careful not to set out a kind of ethical ontology of therapy based on prescribed rules and procedures which would go against the grain of Levinas's work. Nonetheless there are practice implications of an ethical approach to therapy. For Levinas the beginning point for ethical discourse is how another person *affects* me at a face to face level. Here the physical presence of others and the importance of welcoming is emphasized as well as what transpires at a nonverbal level of the body. The ethical therapist is also attuned to inner experience, which can inform thinking and reflection in the presence of

others. Likewise the Levinasian therapist is open to being disturbed or surprised by the Other and the unique meaning and story of persons in the world. This includes both what happens inside and outside of therapy.

To represent another purely in terms of a psychological category or concept does them violence; it is to take over another human being with a language or approach. A therapist simply applying a technique or model stands outside the other and is not in an ethical relationship where the person is put first. Therapists who disregard this ethical relation risk violence in their therapy whatever approach they use (5). At the same time a Levinasian therapist would not deny objectivity or science in therapy but ask how technology or professional knowledge can be applied ethically? Here the ethical relation is not one particular way of doing therapy but a stance adopted *within* a therapy approach or model of choice. Ethical therapists are sensitive about *how* they use a therapeutic language; the relation to the other always takes precedence over theory, technique or method. What is deconstructed is the totalizing approach of a modern therapy that overrides the personal, rather than the techniques themselves which means a therapist's prior training and expertise can remain an integral part of an ethical approach.

Undoubtedly Levinas would have more affinity with relational, contextual and meaning based approaches to therapy like narrative and family therapy or psychoanalysis (Cohen, 2002); nonetheless an ethical stance can be adopted within scientific approaches such as cognitive therapy and biological

psychiatry. Insofar as therapists working within these models demonstrate a collaborative and relational awareness and a non-totalizing use of language they are ethical in a Levinasian sense. This means all therapeutic approaches are available to the discursive therapist who from a stance of hospitality can engage in respectful conversation with more scientifically-minded colleagues about ethical narratives in therapy (Larner, in press).

As noted an advance in discursive therapy does not preclude a *return* to modern therapy and psychology in consolidating what is useful in the service of others. As Pare (2003) notes discursive therapy is not the “New Brand X”, rather the ethic more than the model is key; the difference is *how* interventions are applied. Thus my professional training happens to be in psychodynamic and family therapy, but this does not prevent me using aspects of behavioral and cognitive therapy as part of an ethical relation. In this sense discourse ethics straddles the Saying and the Said or the modern and postmodern as *paramodern*.

To close, when the therapist allows the voice of the other to be heard above the clamor of one’s own, whether it is the inner dialogue of reflection or the spoken knowledge and wisdom of the profession, therapy enacts ethics. Whatever language of therapy is spoken, it belongs first to the other, *for* the other. Levinas is said to think and rethink the ethical idea in copious forms and Derrida compares his work to the sea lapping at the same shore (Davis, 1996). If

so, the land is called Other, an infinite world beyond our comprehension where the ethical relation is sacrosanct.

Notes

1. This meaning of discourse derives from the Latin *curro curs*-run 'to let things run' as in 'rambling, digression, expatiating or copious speaking and talking' (The Australian Pocket Oxford Dictionary, p.202). However the term also refers to a professional or technical language based on prescribed beliefs and covert practices of power.
2. For Levinas the ethical is also the spiritual. As Derrida (1999) notes in his eulogy, *Adieu To Emmanuel Levinas*, "ethics" is a Greek equivalent "for the Hebraic discourse on the holiness of the separated (*kadosh*)" (p61).
3. This has important implications for social constructionist theory I am unable to develop here.
4. Outcome research shows multisystemic family therapy is an effective intervention (Cunningham and Henggeler, 1999) and this professional knowing can be integrated into the primary ethical stance I am advocating here.
5. It is interesting that recent research shows an ethical attitude of egalitarianism, altruism and hospitality rather than divisive self-interest benefits others in terms of prosperity and well-being (Fehr and Gächter, 2002).

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Chapter 6: Intersecting Levinas and Bion: the Ethical Container in Psychoanalysis and Family Therapy¹⁰

In a previous paper, I defined a common ground between psychoanalysis and family therapy as constructing a narrative or dialogical space to explore personal and relational meaning in the therapeutic relationship (Larner, 2000). Whereas the focus for family therapy is the systemic pattern of relationships including the therapist/family interface, in psychoanalysis it is the emotional intensity of the transference relationship over the long term (Bertrando, 2002). I suggested that analyst and family therapist both integrate not-knowing and knowing in a both/and or deconstructive stance of *knowing not to know*. Following Bion, this creates a narrative container, or reflective space, for thinking to emerge in the therapeutic conversation (Flaskas, 2002).

In this chapter, I intersect Bion's thinking with the ethical philosophy of Emmanuel Levinas in the idea of the 'ethical container'. For Bion, containment is a relational process: a being with the patient in thoughtful reverie where emotional and symbolic meaning is held, interpretations are ventured, and thinking develops. For Levinas, the foundation of thinking is the ethical relation

¹⁰ Published as a book chapter in Flaskas, C. and Pocock, D. (2009) (Editors). *Systems and Psychoanalysis: Contemporary Integrations in Family Therapy*. London: Karnac.

to the other. The ‘ethical’ is the incomprehensible, the disruption of knowing by not-knowing in face-to-face encounter with the other (Larner, 2004). This intersection proposes therapy is, first and foremost, an ethical relation where the therapist’s stance of knowing not to know constructs an ethical container for thinking and for relational meaning to grow.

The experience or practice of therapy is always larger than theory can contain and recognizing this is already to enter the ethical relation. As Carmel Flaskas (2002) has commented, “Therapy is a human activity—indeed at times, alarmingly personal—and the stuff of therapy is the lived experience that clients bring, regardless of the framework of therapy we find ourselves working in (p. 8)”. For this reason, the chapter begins with a detailed description of a piece of family therapy practice. Then I describe the ethical philosophy of Levinas and its intersection with Bion’s thinking. More systemic reflection on practice follows to illustrate the ethical container. ‘Containment’ is defined as an ethical relation to the other that takes in the person’s affective experience, beginning a process of thinking and reflection in the therapeutic conversation.

Ghost of the rabbit ears

James, aged 14 years, was referred by his mother for a range of problems including anxiety, angry outbursts at school and home, truanting, refusing schoolwork, lack of motivation, depression and sleeping difficulties that had him sharing her bed over several months. Four years previously, his father abandoned the family to live with another woman making no subsequent

contact. In the first family interview, attended by James, his mother, and grandmother, the sudden loss of this relationship was presented as a major issue. As the mother put it, “His Dad not being around; it’s always James and I”. The grandmother chipped in, “He feels insecure”. James agreed he felt insecure saying he had recently made another unsuccessful attempt to contact his father. A related discussion explored the question of who steps into father’s shoes to provide discipline. James complained of being bossed around by women of the house including his older sister: “I feel like I’m not allowed to do anything. And then you say how much you hate Dad for what he had done”.

During the interview, I was mindful of my own similar experience at 10 years of age when my father disappeared to live with another woman and I never saw him again. I could feel the depth of James’s sadness stirring my own emotions. I thought about the massive impact of the pain of abandonment on my life, its effect on my mother and the years of psychoanalytic therapy I needed to deal with it. The experience touched me deeply as I thought “this could be me many years ago”.

The next family session tracked family interaction and conflict around James’s sleeping problem and not attending school. James denied feeling scared about sleeping in his own room, but admitted it was isolated and “creepy”, complaining that his bed was uncomfortable. We discussed buying James a new bed if he slept in his own room for 2 weeks. James’s anger towards his father was raised, which he separated into two parts: “Because he left me” and

“Because of what he did to my mother”. I ventured a possible link between James’s anxiety, sleeping problem, school resistance and his anger about being abandoned by his father. For the mother and grandmother, James had become a “bully” in his own family “throwing his weight around” as the only male in the household.

In the third family interview with James, his mother and older sister, they reported that he slept upstairs in his grandmother’s bed for one week while she was away on holiday. In the subsequent week, the mother purposely locked her bedroom door, so James bedded on the floor in his sister’s room, going to sleep watching TV. Our conversation touched on the verbal abuse the family had suffered from the father; as the sister explained: “When Dad was angry it wasn’t because of anything we had done, he let his anger out on the family”. At this point James said he couldn’t sleep in his own room because it had a creaky floor: “It feels like someone walking in the room”. I asked whether having a TV in his room might make a difference and he answered: “It would drown out the creaky noises”. However the aerial extension would not reach his room so I suggested: “What about getting some Rabbit’s Ears?” I was thinking of a portable antenna sometimes called in slang ‘dog’s ears’. In response to my faux pas the whole family broke into prolonged laughter, James in particular cackled and repeated my phrase several times. After this merry interlude his sister said a TV in James’s room might make a difference and she offered hers, though the mother was sceptical. James repeated “It’s a freaky room” and talked about the

possibility of ghosts in the house and the scary movies he had been watching such as *The Ring*.

Still in reverie about the resonance with my own emotional experience, I ventured the interpretation that the “creaky noises” James heard brought to mind the footprints of his absent father. James appeared to wince under the brutality of my suggestion and, turning towards me, said with biting sarcasm: “Oh you’re good, very good”. During the family interviews I had been aware of his frequent put-downs and demeaning attitude towards me. The ‘joke’ and laughter about the rabbit’s ears was really at my expense showing me to be the ‘clown’ I really was. Perhaps I made the error unconsciously as an ethical gesture in the hope that exposing my own emotional vulnerability to James might be reciprocated. Reflecting on this later, I saw my interpretation as thinking-through the emotional experience of fear, sadness and anger James evoked in me that led to my reverie about my father.

A moment after James’s sarcastic comment he conceded: “I’ve never really thought about it that way before”. Perhaps, initially, he was angry at me for exposing his vulnerability— his sarcasm concealing that what I said had hit the mark; it was James’s cry of pain and anger about his father directed at me as a good-bad therapist. Then he acknowledged thinking differently about himself, that I could be ‘good’ or helpful in clarifying his experience; he accepted my meaning and began to *think* it. This was a crucial moment in the therapeutic relationship.

After James's acknowledged my interpretation, I sensed an invitation to continue and offered: "The footprints of a father who could give you a sense of security and look after and protect you". Ghosts not only *haunt* with the terror of death, loss or absence but are visitations from a familiar figure, for James the absent-presence of his father as protector in the house. The mother contributed: "I felt that as a child—you know, safe". Mindful that James's teasing posture towards me meshed with my anger about my father-abandonment, I repeated: "Could someone walking around, making creepy and creaky noises in your room like a ghost, be your angry feelings about Dad not being there for you?" James rebuffed me saying: "I'm still thinking about that" but appeared to take it in. The sister said that she was sometimes scared of ghosts and the family recounted a memorable, though scary, Ghost-tour 4 years ago—co-incidentally around the time the father left.

The session ended with the mother saying that James was better behaved after our sessions, and he agreed saying: "I don't feel as angry". For various reasons I didn't see James and his family again; an ironic repetition of both our histories. On follow-up, six months later, the mother reported James had "settled down" and was sleeping in his own room with plans to have TV connected in the near future. He had "come a long way", he was more mature and talking about his feelings had been beneficial. On further follow up nine months later, James was "getting there" and attending school consistently.

Levinas and the ethical relation

“To approach the Other in conversation is to welcome his expression, in which at each instant he overflows the idea a thought would carry away from it. It is therefore to receive from the Other beyond the capacity of the I, which means exactly to have the idea of infinity (Levinas 1969, p. 51)”.

Emmanuel Levinas is a post-structuralist French philosopher and pre-eminent thinker of our age, influencing diverse fields of study including philosophy, theology, feminism, and psychology (Davis, 1996; Critchley and Bernasconi, 2002; Diprose, 2002; Hutchens, 2004). He was a contemporary and colleague of Derrida, inspiring him to define deconstruction in terms of hospitality, justice, and the ethical. As Derrida (1999) says in his eulogy *Adieu*, Levinas awakened us to ethics and responsibility. The ethical philosophy of Levinas is an emergent voice in postmodern psychology and therapy (Gantt and Williams, 2002; Sampson, 2003; Larner, 2004).

For Levinas, the ethical is distinct from traditional ‘ethics’ as morality; rather, it concerns the *face-to-face* encounter with another person as a foundation for thinking, subjectivity, and being. This ‘ethics-first’ philosophy is radical. In contrast to hermeneutics that begins with the interpreting subject, it starts with the *other* who breaches our understanding: “The face is present in its refusal to be contained. In this sense it cannot be comprehended, that is, encompassed.” (Levinas, 1969, p. 194).

Levinas's account of the self and thinking is systemic or relational. The self is awareness of the other-in-me. Thought is not contemplation of a unity, totality or the same, but of difference, separation and the other: "Thought and freedom come to us from separation and from the consideration of the other..." (Levinas, 1969, p. 105). The ethical relation to other is what forms our person: 'I' is always *you-I*. The other is a condition of subjectivity or having a self at all; one cannot know oneself except through the other. The other comes first and this ethical relation makes knowledge and thinking possible (Larner, 2004).

What, then, could the above statement by Levinas about infinity possibly mean for therapy? At first glance it appears to throw into doubt any notion of what therapy *is*. Certainly it becomes less what I do *to* others and more what my experience of the other does to me! Taken beyond my understanding, I am moved to *respond* to the other. I move away from objective knowing and categories that put my experience of the other into words—what Levinas called the '*Said*'—into the relational encounter of not-knowing: what he calls '*Saying*'. As a therapist, I become aware that the other is so much more than I can possibly think— the very idea of transcendence or infinity.

What changes in the encounter is how I see *myself*; in part, therapy is a gift I receive from the other. This calls to mind the *irreverent* stance of Cecchin, Lane, and Ray (1994), where the systemic therapist takes responsibility for changing his or her beliefs and prejudices rather than those of others: "But it is at the moment when the therapist begins to reflect upon the effect of his own

attitude and presumptions that he acquires a position that is both ethical and therapeutic (pp. 8-9)". In relation to other, I become aware of my responsibility in the face of the unknown, which as Derrida (1999) explains, "...is the element of friendship or hospitality for the transcendence of the stranger, the infinite distance of the other (p.8)". In therapy, welcoming the other—or hospitality—comes about by exposing the inadequacy of what one knows, which is tantamount to coming face-to-face with the suffering of another human being.

Translating this ethical philosophy to therapy as a person is always beyond my grasp or understanding, I resist totalizing or violent knowledge: ideas that assimilate the other's experience and story in terms of preconceived categories, ideas, theories or approaches to therapy, whether these are theories from psychoanalysis, cognitive therapy or family therapy. The ethical therapist, open to an experience of *other*, is moved by the uniqueness of each therapy encounter. In receiving the other, I become aware she is separate from me; as *other* he overflows the 'I' who thinks only in terms of knowledge and understanding. This does not throw meaning to the wind; rather it becomes grounded and thickened in relational experience. In a face-to-face encounter with another human being, my understanding is enriched beyond possible understanding. There is relation in difference, connection in separation, space in the between.

What is interesting, is the framing of this ethical process within the context of family therapy practice. The painful feelings that James evoked in me

can be described as a systemic mingling of our subjectivities, a resonance between our experiences that allowed me to frame the thought that feelings of abandonment fuelled his angry and defiant behaviour. However, to James, my interpretation seemed to feel like an attack on his person, bringing home the pain of his father's abandonment leading to his sarcastic response about me being 'good'.

Yet it was in the context of my faux pas about Rabbit's ears, a moment later that he seemed able to take in my meaning. Perhaps the joke exposed my vulnerability, humanness and lack of knowingness in the face-to-face relational encounter with his person. More than merely comprehending or interpreting James' predicament, I was *disturbed* by it, taking it in as emotional experience at the level of the body. Whatever else happened, this ethical gesture of welcoming and being host or hospitable helped James to participate in a dialogue of shared meaning and to begin to think differently.

For Levinas, thinking is not a private activity of cognition, or self-knowledge, but acted out in a relational field. To have a self is to be thought by the other, to become aware of the other thinking in me and to put myself in their place. Peter Fonagy and colleagues describe this relational process as developing a mentalizing or reflective capacity. In human attachment the infant develops a sense of self by internalising the experience of feeling known to the other. They describe a similar process occurring in the therapeutic relationship where the therapist's thinking fosters the patient's mentalizing: "The crux of the

value of psychotherapy is the experience of another human being's having the patient's mind in mind (Fonagy and Bateman, 2006, p. 415)".

I am suggesting this relational process of thinking is ethical in Levinas's sense. In proximity to another, it is to let oneself be *affected* or disturbed by the other, to *take in* their experience and think it, which as we shall see is what Bion calls containment. As Alphonso Lingis says, introducing his translation of Levinas's (2004) *Otherwise Than Being*, "Being exposed to the other is being exposed to being wounded and outraged (p. xxiv)". This requires the therapist to be in a state of receptivity towards the other's pain and fragility, feeling it *as if* it were one's own. Yet the other is infinitely more than I can ever attune to or understand. While beyond my understanding, only through the other can I understand at all? Under-standing takes place *in relation to* other where I am extended to think beyond myself; it is literally to *stand under*, to approach the infinitely other with curiosity, wonder and awe.

Bion's thinking container

Bion's metaphor of containment elaborated Klein's notion of projective identification from an intrapsychic mechanism into a relational process of interpersonal communication between infant/patient and mother/therapist (Vaslmatis, 1999). In a state of reverie the mother takes in the infant's emotional experience providing reassurance and preventing anxiety from overwhelming the infant's developing self. Likewise, the analyst in partly unconscious reverie begins to experience, think, understand and put into words

the projected preverbal emotional distress of the patient (the contained).

Containment can be described as an intersubjective process in the countertransference relationship. As Vaslmatzis describes it, the container-contained relationship is reciprocal, where the therapist's reverie is resonant of the patient's emotional struggle: "He was now the person who contains and who suffers (annoyance, wondering); he was the container of her projections (p. 436)".

As I have suggested previously (Larner, 2000), postmodern psychoanalysts influenced by Bion, like family therapists (cf. Flaskas, 2002), frame such analytic ideas in terms of an intersubjective or relational model, which, "considers relations with others, rather than drives, the fundamental element of mental life (Marzi, Hautmann, and Maestro, 2006, p. 1302)". Following Bion, reverie, thinking and reflection to contain emotional experience are seen as central ingredients of psychoanalysis. Can a similar process occur in systemic therapy? Possibly in a different way.

The work with James and his family described a thinking container where the therapist helped to shift the emotional culture or *ethos* of the participants (Pocock, 2005). As a systemic therapist, I received their emotional experience constructing a thinking space for reflection and conversation in the therapeutic relationship (Flaskas, 2005). Here the systemic therapist integrates a key ingredient of containment: what Fisher (2006), reading Bion, calls the emotional experience of 'feeling curious'. In psychoanalysis, the container is provided by

the analyst “wanting to know and understand, not from an emotional distance, but by experiencing those emotions and yet retaining a K-state of mind (p. 1231)”. The analyst’s curiosity is ‘contagious’ inviting the patient to do likewise so “they might too begin to wonder (p. 1235)”. This stance of ‘negative capability’ described by Bion is not-knowing, the capacity to remain in doubt and not find answers too quickly.

This is the link between Bion’s notion of containment and the ethical relation in family therapy: the desire to know in a totalising way is relinquished (Larner, 2004). In Levinasian terms, the Said gives way to the Saying; the intellect gives way to the heart, and knowing to not-knowing. Thus in the practice piece, what I *said*—my therapeutic knowing or interpretation about James’s father abandonment—had meaning for him only in the context of not knowing or *Saying*, where my experience of his emotional pain was transformed into a faux pas about Rabbit’s ears.

The ethical is a disruption of ordinary experience by the transcendent where the other as not-me overwhelms or ruptures our thinking. Containment in psychoanalysis and systemic therapy, is the therapist thinking through this emotional experience or disturbance (what Flaskas (2005) calls *impasse*) and communicating its meaning reflexively or dialogically in the therapeutic conversation.

The ethical as knowing not to know

The ethical relation is the container for receiving and thinking the emotional experience of the other. It concerns how to know in a way that resists knowing *all* as totalizing knowledge, being open to what is other, or beyond, knowing. As I have described it, *knowing not to know* is an ethical stance in psychoanalysis and family therapy that concerns less what we know and more *how* we know in the therapeutic relationship (Larner, 2000). Knowledge and expertise is still there but there *for* the other. As Levinas notes, without knowledge, science and technology there would be no ethics because the world would starve (Larner, 2004). Our responsibility as therapists is to *know* enough to be helpful in therapy, as I could be with James, but knowing as not-knowing while participating in the Saying of relational encounter.

This is where the ethical relation like the therapeutic relationship is asymmetrical: like the mother with her baby, as a therapist I am there *for* the other. I think and reflect as a therapist on what knowledge is available to help influence stories of suffering and adversity. As for Levinas, not knowing is really *ethical knowing*, where the other is put first. Here *knowing not to know* takes up the ethical responsibility to know in order to alleviate suffering; at the same time it acknowledges one can never know, understand or comprehend the suffering of another person but only be moved to respond. As Large (2005) explains Levinas: “To think the experience of the Other, which is nothing less than to think suffering, is to refuse to allow this thought to fall into the image of thought (Large, 2005, p. xiii)”.

The ethical is an attempt to think the other as in Bion's understanding of psychoanalysis. The attempt to represent the other by image, interpretation or theory can get in the way of providing a container for their emotional pain (Symington, 1986). Containment is a reflective or narrative space where the therapist/ analyst thinks the client's suffering and gives it back as shared meaning in the dialogue of therapy. Where the therapist is *disturbed* by the experience and resists imposing preconceived meaning, the encounter is ethical. It is *how* we know and act towards the other, an ethical stance that gives knowing a human or relational face. This *knowing not to know* is the common ground between psychoanalysis and systemic family therapy (Larner, 2000). As Odgen (2004) explains, reading and understanding Bion, like doing psychoanalysis, involves "a progressive cycle of knowing and not knowing (p. 290)".

The ethical container

The suggestion here is the container in Bion's thought has an ethical shape. The analyst's not-knowing is an ethical positioning of being open to relational encounter with the other. To understand *other* one must give up understanding as a merely intellectual or rational exercise: give up memory and desire, and take in the experience of the other in the room. This is to experience the other as a person not as an extension of the therapist's meaning, interpretation or image of them. The therapist's first step is ethical; to suspend theory and expectations, to stop the internal chatter of mind in order to listen, feel and be there *for* the

other. Is this so far from Freud's original advice to the beginning analyst to "simply listen" rather than be bothered about keeping anything in mind (Epstein, 1995)? Yes and no!

As a self-reflective therapist I put myself in the place of the other, containing and thinking their emotional experience; this is the ethical relation. However the thinking container is less in the mind of the therapist (as knowledge or interpretation of meaning) or the patient and more in the *relation* between them; in the narrative of therapy that unfolds as dialogue between relational selves. As Bion (1962) says, thoughts wait for thinkers to think (and say) them. This yet-to-be-said, unspoken experience, James stirred in me, leading to my reverie and thinking about the footprints of our fathers.

The therapist allows herself to be *affected* by the emotional experience of the other constructing a thinking container in the relational mind or dialogic space between. This containment begins with the ethical gesture of receiving and thinking the other's pain. As Noreen O'Connor (1998) says "one can be a psychotherapist only through the interhuman emergence of one's own suffering (p. 233)". Thus, my experience with James was a confluence of my old wound and his fresh one. Though I was able to think what belonged where without reacting to his sarcasm, his experience, reflected through mine, opened up something useful for both of us.

In systemic therapy and psychoanalysis, the therapist moved by relational experience of the other constructs a conversational space for thinking

and reflection. Carmel Flaskas (2005) charts this containing process as experience of impasse and Peter Rober (1999) calls it dialogue between inner and outer conversation. Building on these excellent notions I reference it as an ethical container that unfolds between therapist and client in the discourse of therapy (Larner, 2000; 2004).

Thinking arises in the intersubjective curvature of space, as Levinas calls the interhuman. In experiencing you, I am moved to reverie and thought. Your suffering holds up a mirror to my own experience through which I begin to understand and hold you 'in mind'. You, in return, hold me in mind by taking in what I have to say. Yet the mind or thinking container is defined in discourse made possible by the ethical relation. Thus when James says "I'm still thinking about that" in response to my posing a link between the ghost of his father and his anger, he becomes host to my thought. Perhaps, realising I am holding him in mind, he is able to return the ethical gesture and take what I have to say seriously not merely as a 'joke'.

Reflecting on systemic practice

I invite the reader for further reflection on systemic practice in relation to the ethical container. First it needs to be said that family therapy is not the same as psychoanalysis. There is no comparison between the emotional and relational intensity of three to six sessions of systemic therapy and a thousand or more psychoanalytic sessions over several years. The two therapies have distinct traditions with their commonalities and differences well addressed in the family

therapy literature (Pocock, 2006). While the perspective of systemic therapy is undoubtedly *external* relationships (Bertrando, 2002) both approaches work with internal representations of self and others to different degrees.

Both modalities share a common ground of postmodern thinking and constructing a reflective dialogic space for thinking *self* and *other* in the therapeutic relationship (Larner, 2000). In such relational therapies emotional understanding develops in the intersubjective or dialogic space *between* persons. This is what Pocock (2005) nicely calls a ‘system of the heart’ where the therapist, moved by the therapeutic encounter, “makes him or herself available to be affected and to think in the newly forming ethos of the therapeutic relationship (p. 133)”.

Derrida (2000), inspired by Levinas, defines ‘ethos’ somewhat differently as hospitality and the ethical: “It is always about answering for a dwelling place, for one’s identity, one’s space, one’s limits, for the ethos as abode, habitation, house, heath, family, home (p.149)”. In these terms both systemic therapy and psychoanalysis welcome the other into an ethos, habitat or reflective space where thinking of self in relation to others is possible. As Frosh and Baraitser (2003) state, the key question for contemporary psychoanalysis is: “What are the conditions under which it is possible to think? (p. 772)”.

In the practice vignette with James, the inner thinking or dialogue of the therapist became part of the outer conversation between therapist and family (Rober, 1999), grounding relational meaning in shared emotional experience.

As a systemic therapist I was able to ‘take in’ the hostile and derisive projections of James’s abandoned, fearful and humiliated self, spooked by the footprints of his absent-father which, resonating with the ‘ghost’ of my own father, enabled me to think and contribute meaning in the therapy narrative. His fear of going to school and sleeping in his bed suggested anxiety about further abandonment: his omnipotence and derision towards me, a defence against his helplessness. In face-to-face encounter with James and his family, this heightened my emotional disturbance sufficiently to enter a relational thinking space on the theme of father-abandonment. All in the virtual netherland of the ‘what if’ of imagination, a ghostly reception made possible by a ‘joke’ about rabbit’s ears. This is part of what I call the ethical container.

In terms of Levinas I put myself in the place of the other, receiving James’s angry jibes without retaliation (even though I felt their barbs in my person) allowing trust and thinking to develop in the nether space between us. This ethical gesture provided a Bion-like container for receiving and thinking the emotional experience of James via my own struggle with father-ghosts. So we both might eventually say, as Hamlet did to the Ghost of his father, “Rest, rest perturbed Spirit”. As Derrida (1995) notes in deference to Levinas, deconstruction is a ‘thinking of the gift’, a ‘gratitude without thanks’ and a ‘justice’ which is ‘beyond exchange’, where one ‘learns only by receiving’ from the other.

As in Hamlet, the murdered absence of a father contributed to my own emotional dreaming and a kind of madness about rabbit's ears. Following Derrida (1995), for both James and I, this unspoken experience would have, I speculate, put our narrative histories and minds 'out of joint' trapping us in a haunting mourning for the father-ghost who never returns; yet our yearning and expectation of imminent return leaves us anxious and alert to the silent creak of footsteps in the house. Perhaps, like Hamlet, for James the footprints belong to the ghost of the father he has killed, and kills everyday, in oedipal rage as revenge for the injustice of what has been done to him and his mother. It is his own anger come to haunt him, an apparition of the missing father in him; is he the monstrous Uncle who now shares his mother's bed?

Thinking about thinking

Systemic supervision – thinking about thinking – introduces another level of the ethical container. In bringing this therapy narrative to a systemic consultant I wanted her to take in and think about my experience, much like I did with James and his family. This constructs a new understanding and ethos for the therapeutic work; call it 'fine-tuning' if you like or 'adjusting rabbit's ears' to improve therapeutic reception. Among other things, the consultant saw my use of humour as a 'soothing balm' that allowed the unspeakable to be spoken. The family sessions touched on the dilemma for James about stepping into his father's shoes while still grieving for him; they raised the spectre of the ghost

that could not be spoken about, by gradually introducing the theme of the *no-father*.

For Bion, the prototype of thinking is the infant's "thought of the breast, imposed by the reality of the no-breast, which is necessary for thinking in the object's absence (Sandler, 2006, pp. 190-191)". Or as Eisold (2005) puts it: "We continually seek containers for our painful experiences of absence, and the thoughts they give rise to in us are continually experienced as persecutory or insufficiently gratifying (p. 361)". In this way, thoughts exist before there is a thinker to think them; the thinking self begins with emotional experience first contained and thought by the other.

Now, for Levinas, maternal receptivity is the ethical relation per exemplar. As the psychoanalyst Chetrit-Vatine (2004) notes: maternity, pregnancy and the womb is a metaphor for the capacity to make a place for the other "a space of a relationship to an other in me... (p. 845)". Thus the French for *womb* is 'matrice' but in Hebrew it is 'Rechem', from which derives the word "Rachamim" or compassion. Like the mother who acts as a receptacle—or container—to receive and modify through reverie the emotional experience of her infant, the analyst turns toward the face of the other in a gesture of unconditional hospitality, empathy and ethos. In therapy it is the other who brings forth my thinking as an abode for unspoken experience to be thought and narrated.

This ethos or ethical relation formed part of the therapeutic container in systemic therapy for James and his family. The consultant suggested that TV acted as a transitional-like object for James's anxiety allowing it to be safely received and named providing a container for the family narrative to emerge. My gaffe helped to provide a space for reflection about what could not previously be thought. Linking father-absence and the footprints to the rabbit's ears allowed imagination to enter the narrative. It put my therapeutic interpretation *on* TV, where the painful could be talked about in acceptable form as in a *show*. Thinking now, it became a kind of family ghost-tour, a playing with unreality where fantasy provided a portal into the real world.

The consultant commented that this medium provided a way of thinking *no-father* without really doing it. My interpretation was a no-interpretation; my knowing a laughable not-knowing that could be taken on board by James in his own time. The humour and laughing with/at the therapist was an important part of the container allowing the experience of fear, anxiety and belittlement to be approached as father-abandonment. Rabbit's ears like the therapist are not 'all there' or there at all (think the mad Rabbit alter ego in the cult film *Johnny Darko*); they are ghost's ears, like footprints or 'flags' of our fathers.

Conclusion

In terms of Bion and Levinas, therapy is an experience of the mysterious and impossible; it is reaching out to other in the imagination. I imagine your suffering even though I cannot experience it because it is not mine but yours.

You are who you are and I am who I am, though who we are depends on our relation to each other. I reach out to you and you reach back to me and then we reach out to each other, like me to James and finally James to me. The difference for me as a therapist is I do this *for* you; that is my job or positioning in relation to you, the ethical context for coming together in dialogue.

Together we come to experience, think and say the unbearable— that which cannot be said except in this context of therapy—where one person tells another what they cannot tell anyone else. What you tell me, I receive as a gift in wonder that you privileged me to hear your story. I give back to you my attempt to feel and think about your pain. I put myself in your place and think the possibilities for change *as if* you were me, as if I was in therapy and you were listening to my story. This thinking as containment is the ethical relation. I think for you, yet you think through me. There is an exchange of thinking in the abode of our relationship. This is the intersection between Bion and Levinas and between psychoanalysis and systemic therapy.

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Chapter 7: Exploring Levinas: The Ethical Self in Family Therapy¹¹

Abstract

From a systemic perspective persons are relational beings located in wider systems of interaction, conversation and meaning. As for social constructionists the self is positioned and storied through language and dialogue. Yet is the self no more than the multiple conversations and relations it enters into? Systemic therapists informed by psychoanalytic thinking describe a reflective self responsive to inner conversation about emotional experience (Flaskas et. al. 2005). Those working in mental health services contend with the biological and ‘cognitive-mindful’ self. Perhaps the self can be defined in many ways or languages as a deconstructive both/and. In this paper the systemic, relational or dialogic self in family therapy is discussed from the perspective of the ethical philosophy of Emmanuel Levinas. For Levinas ethical intersubjectivity is what makes subjectivity and thinking possible. The self is respons-ibility to other or as Derrida (1999) says “consciousness is hospitality (p.48)”. Yet for both Derrida and Levinas the relational self is also a separate

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and unique self. The ethical self is discussed in relation to family therapy practice.

Introduction

In a systemic paradigm persons are described as relational beings located in wider systems of interaction, conversation and meaning, with individual experience understood in contextual terms (Vetere and Dallos, 2003). As for social constructionist therapists the self is positioned and storied through language, dialogue and narrative (Anderson, 1997). Yet are persons defined only by the multiple conversations, dialogues, stories and relationships they enter into? What about the contribution of biology, the body, emotional experience, reflection or thinking in constructing an idea of self?

Family therapists working in psychology, psychiatry and mental health today contend with the self of neuroscience, the biological self of psychiatry or the ‘cognitive-mindful’ self of clinical psychology, all of which make valuable contributions to therapy. A fascinating aspect of current neurobiological research is the exploration of mind and consciousness as interface between human relationships and the developing brain (Seigel, 2001). There are strong links between neurobiology and family therapy in the burgeoning field of infant attachment research.

Systemic therapists informed by psychoanalytic thinking describe the reflective self of the therapist attuned to thinking and feeling in the therapeutic

relationship. Here Flaskas (2005) combines “narrative and/or systemic and/or psychoanalytic ideas” (p.122) to help work through the therapist/family impasse.

It would appear there are many languages for defining the self in family therapy. As McNamee (2004) suggests, promiscuity or mixing up different theories and discourses can be beneficial for family therapy practice. Where relational and dialogic engagement is the priority any therapy can be seen *as* socially constructed: “Each model of family therapy becomes another *voice*” (p.236).

In the spirit of promiscuity or what I call the ethical relation, the self can be described in biological, neurobiological, cognitive and genetic terms *as well as* narrative, cultural, relational, dialogic, systemic, social, psychodynamic and spiritual metaphors. All these ways of understanding self inform a diversity of approaches in family therapy. Thus Bowenian and object relations family therapy understand the self as coherent and integrated, whereas narrative therapy prefers a more fluid and decentred approach.

Deconstructing the postmodern self

As for Cecchin et al (1993) the challenge is how to approach theory lightly, irreverently and with a sense of play and difference, which allows *many* languages for speaking the self (Larner, 2005). Here to be dialogical concerns the ethical or *how* we speak and relate to each other, rather than theory or replacing one epistemology (e.g. modernism.) with another (e.g. social

constructionism). What is deconstructed is discourse that imposes a way of thinking, knowing or speaking, *forcing* a choice between this *or* that paradigm. This can be totalising or violent, whether it is modern or postmodern.

Turner's 1838 painting *The Fighting Temeraire* in the National Gallery in London, recently voted the most popular artwork in Britain, shows the Royal Navy warship being tugged to her last berth to be broken up. There is something ominous about the imminent destruction of this old world beauty in the relentless march of modern technology. Similarly a postmodern tug pulling the modern self to oblivion risks the very power and violence of language it purports to resist.

As I have argued previously, deconstruction does not replace one discourse with another; it is not a destructive operation performed on a text from the outside, as its popular interpretation of 'taking things apart' suggests. Distinct from post-modernism, it is an ethical movement that challenges the hegemony of a discourse from *within* (Larner, 2002). Derrida (2007) reads a text, paradigm or discourse with respect, disrupting what he calls the language of the *One* by bringing forth other voices in the text. Rather than being iconoclastic he appreciates the architectonic beauty of modern theories of the self, Cartesian, Kantian Freudian or otherwise. As he said before his death: "No, deconstruction is always on the side of the yes, on the side of the affirmation of life" (p.51).

Levinas (2004) dedicated his last major book to the memory of the holocaust where human beings were effaced by a violent knowledge and technology.

Simply put his ethical response is to put the relation to the other before knowledge or theory of being. To be face to face with another person overwhelms all our concepts and theorizing and evokes an infinite experience of responsibility: “To be in relation with the other face to face-is to be unable to kill” (Levinas ,2006, p9), which applies as much to thoughts and language that override the other as murder.

This is why Derrida (1998) who was profoundly influenced by Levinas says language “opens out onto a politics, a right, and an ethics” (p.24). Here: “My language, the only one I hear myself speak and agree to speak, is the language of the other” (p.25). Following Levinas, Derrida (2000) calls this an *ethic of hospitality*, where the ethical *is* to be hospitable towards the other. To be in one’s home, to speak my language, to be a self, one must first take in and speak the language of the other.

Elsewhere I have suggested to be a systemic therapist *is* to be hospitable, inclusive and integrative in this sense. Of all the therapies family therapy speaks the language of the other; bringing “one part of the whole into conversation or dialogue with the other” (Larner, 2003, p.212). Family therapists speak their own language by first speaking the language of relational others. As I see it such hospitality applies not just to our work with clients but relating to colleagues who speak non-systemic languages like cognitive therapy or biological psychiatry.

Dilemma of the relational dialogic self

This produces the following dilemma: if to be systemic is to speak the language of non-systemic others, how does one remain systemic? This is relevant for systemic practitioners like myself working in non-systemic contexts like mental health services and is not unlike the paradox of the self. If the self is formed totally through the voices of relational others how does one define an individual self?

The eminent social constructionist Edward Sampson (1993) marks this dilemma of the dialogic or relational self as follows. Genuine dialogue requires each person adopt a specific and unique standpoint as a separate individual. If so, as Sampson asks, “how can we have a relational view of human nature and simultaneously refer to a person’s specificity?” (p. 21). Here Sampson advocates a state of dissonance or tension about whether the self is independent or relational, “even if it retains a dilemma troubling to those who require neat solutions...” (p.23).

Likewise for Derrida (1993) such aporia or impasse between polarities like self./other, public/private etc. are to be experienced or endured rather than resolved, much like a double bind. They are the stuff of deconstruction and life. In family therapy I call it a *paramodern* stance, where the modern and postmodern sit together despite the tension (Larner, 1994).

Self other

From the perspective of the ethical philosophy of Emmanuel Levinas, the unique subjective experience that is self begins with the other; it is awareness of

the other-in-me. In proximity to the other, looking at their face, one is moved to respond. Ethical intersubjectivity is what makes subjectivity and thinking possible. The self *is* responsibility to other, or as Derrida (1999) says “consciousness is hospitality” (p.48). Yet for both philosophers the relational self is also a separate and unique self, which allows one person to take responsibility for another.

Thus Derrida (1999) explains the relation between ‘I’ and ‘you’ as irreplaceable or unique, where the self is a “zero-point of space and time... That is what I mean when I say ‘I’, and in this place ‘you’ cannot be, it’s irreplaceable. I can’t be in your zero-point” (p.70). As he suggests, for Levinas the other is *other* precisely because he or she is separate from me; there is an infinite alterity or difference where, “the separation is the condition of the social bond” (p.70).

The argument of Derrida and Levinas is that ethics and social justice requires a notion of self that is separate and unique, which cannot be reduced to a discursive, dialogic or relational account. However this does not take us back to the Enlightenment autonomous rational self, rather there is a sense in which deconstruction interrogates both perspectives. The self is distinct from other *while* in relationship.

As systemic therapist Carmel Flaskas (2002) argues, persons generally experience a continuous, autonomous and stable identity:” most of us hold an image of ourselves across time and place and relationships-a sense of core self,

a sense of a physical and emotional being, an embodied self, an experience of the autonomous self” (p.91). Without wanting to return to the modern self, Flaskas suggests adopting theory flexibility in moving between different levels of self description.

In other words the self is a complexity; it is both relational *and* autonomous. There is other *and* me. To be otherwise or different there must be an “I” separate from the other in me. While put in question there is still need for an idea of self as a separate inner experience or consciousness of “I” apart from “you”. There is you and I but also a third, which is the space between us in the ethical relation.

Levinas and the ethical self

For Levinas personal responsibility requires a singular corporeal self with ‘a deep sense of autonomy’, that stands apart from its constructed public or social identity (Fagenblat, 2007). The self is not merely contextual, but an existential subject who requires ontological independence in order to exercise agency and responsibility for others. Here the ethical self is distinct from the postmodern self.

For Levinas (1969) independence is the key to social connection and the relation to the other. As he notes: “Justice would not be possible without the singularity, the unicity of subjectivity” (p.246). Thought and the self is contemplation of difference, otherness and transcendence, of the other *separate*

from me: “Separation is the very constitution of thought and interiority, that is, a relationship within independence” (p. 104).

The paradox is by opening out to the suffering and humanity of the other, the self loses self. Yet while the self is formed by giving itself away there has to be a self to give away. For an ethical position towards the other to be possible, the self requires a degree of self-autonomy. To understand the other one must be separate yet connect at the same time; to have empathy or join with the experience of another person, requires the self to stand alone, yet be with the other. The ethical self is *more than* its social being or dialogic construction in language, it is what makes the latter possible. To be in relation to the other one must first be a self, but one is a self through relation to the other, and so it goes round.

The decentred centred self

If you have ever listened to Ornette Coleman’s music you will have an idea of the postmodern self as a dialogic polyphony of multiple voices, as Peter Rober (2005) borrowing from the philosophy of Bakhtin eloquently suggests. In the free jazz collective there are simultaneous harmonic stories where the instruments improvise in parallel but disconnected voices. The bassist has one story to tell, the saxophone, piano and percussion another, much like the multiple dialogues of the self expressed in a dialogic or social constructionist paradigm (Anderson, 1997; 2005). Yet in Coleman’s music, which I had the privilege to recently hear live at the Sydney Opera House, there is integration

and connection within apparent chaos. The multiple instrumental voices of disharmony somehow express a melodic unity; structure emerges from its disruption.

Similarly may I suggest the decentered postmodern relational self expresses a layered harmonic unity or modern voice of independent self-awareness we call “I”? What is unique to Derrida and Levinas is the idea such self-identity is formed through the ethical relation to other. As Derrida (1995) puts it: “The question of the self: “who am I?” not in the sense of “who am I” but “who is this ‘I’ “that can say “who”? What is the “I,” and what becomes of responsibility once the identity of the “I” trembles *in secret*?” (p. 92).

Rather than moving *from* inner *to* outer (as for the modern self), or from the social/outer to inner conversation (for a dialogically or socially constructed self), the ethical self deconstructs or works *within* the self/other duality. Self awareness or reflective experience is possible through the relationship to the other. Levinas (2004) calls consciousness, “relationship with beings” (p.99), but it is consciousness nonetheless.

Persons come into being through the voices of others speaking within, but as unique and independent individuals capable of a rich experience of inner life such as imagination and thought. This is what makes possible the connection between different ways of thinking the self, as dialogical, systemic, cultural, narrative, relational, neurobiological, psychoanalytic, experiential, emotional etc.

Practice Illustration: The egg self¹²

Here I will attempt to illustrate the ethical self as both relational and independent with an example from family therapy practice.

Nicole is a 14 year old girl referred for depression, missing school, social withdrawal, overeating, bulimia and suicidal ideation. Nicole had been cared for by her grandmother and mother since birth after the family left the father because of his violence. There is a long history of attachment issues and relational conflict between Nicole and her mother. Nicole was referred to me after being treated with an antidepressant and cognitive therapy by a psychiatric registrar.

In our first session Nicole told me she had expected things to improve from therapy but they hadn't. "I wanted to be happier." A common theme was her feeling rejected by her mother and friends and the sadness that resulted: "I feel they don't care". I wondered aloud if Nicole's early life experience and history had contributed to this sensitivity about rejection and she replied: "I feel I'm not worthy or good enough, I feel unloved...I feel shaky on the inside...I feel like an egg with a hard shell and a soft middle". I held this metaphor "in mind" and in the next session asked her to draw it for me.

¹² To protect privacy this is a constructed therapy narrative using fictional names.

The following conversation took place six months later, after seeing Nicole weekly for individual therapy as well as joint sessions with her mother focusing on their relational and attachment issues.

Therapist: Nicole I'm just looking at your drawing here, how long ago did you do that?

Nicole: About six months ago

T: Okay. Can you remember at the time why I asked you to draw this?

N: Because you didn't quite understand how I felt about things. I presented really bubbly, but I have depression, so you didn't understand why I wasn't displaying it so much, like signs of being depressed.

T: At the time what did you call it?

N: I called it like an egg. The centre of it is like the yolk. And that (points to the black) is how I felt deep down. Its black, dark and its depressing and I felt really sad on the inside. And the yellow was what people perceived me to be. What they saw me as, which was happy, like (in a raised voice): "Hi, how are you going" and stuff like that.

T: Okay and the red around the perimeter?

N: I think that was like the very external, a coating. It was in three layers. The middle of it was like an inner core and the rest of it was how I presented and the red on the edge was the coating of the whole interior.

T: Like the boundary or the shell and this was everything inside, the bits of you.

N: Yeah

T: At the time you thought the black was *you* and I remember saying “Hey, I wonder if the yellow is as much a part of you as the black”? It’s not making a judgment one way or the other.

N: Yeah

T: So this drawing for you captured something about how you were feeling and was an attempt to help me understand and I think it did.

N: Yeah it was the only way I could explain it. It’s hard when people say “Why are you depressed, you seem so happy”, and I think you don’t really know me at all. In a sense, there’s this whole feeling of people not understanding you and you feel all alone. That’s like the inner core thing.

T: The inner core.

N: It does remind me of an egg actually. I feel like an egg (laughs), with chocolate.

T: I was interested to know where you are at now and how you see yourself in relation to this drawing.

N: Umm. Definitely less black (laughs)...It’s like smaller. I guess its kind of a mixture of things...I’m not as sad anymore and not feeling like I’m hiding inside from everyone. I think most of it is on display for people to see.

T: Mmhh!

N: I think the interior of my egg the little shell thing is probably a mixture of black and yellow, not so much a core.

T: Okay I see what you mean.

Therapeutic Reflections

In the therapy narrative Nicole realizes the ‘core’ self she identified was only part of her self-story. She is able to reflect on the whole from a more integrated standpoint of subjective unity, that she is *more than* this *or* that self, the depression or bubbly bits. Hers is a multiply voiced identity that is also a separate reflecting self she calls “I”.

From a dialogical stance, I challenge her belief in a core essential depressed self, introducing the idea of a self constructed by multiple meanings. Yet at the same time there is recognition of Nicole as an integrated, separate, self-reflecting and unique individual capable of taking responsibility and agency in her life.

While Nicole is a separate person to me, *who* she is and who I am as a therapist are defined in relation to each other, in the conversation and dialogue we have together. When that dialogue comes to an end, we continue to exist separately as independent selves across different time and space narratives.

As a therapist I stand separate from Nicole, yet I am there for and *with* her, welcoming her to share her experience with me. In the ethical relation I work within the therapeutic relationship rather than apply techniques from the outside. There is a dialogic interplay between her narrative and my thinking as therapist that unfolds in the sessions. Yet this is a one-way non-symmetrical relationship, where I am responsible for Nicole, or as Levinas quipped, in the

ethical relation “the buck stops with me”. Recall the music of Ornette Coleman, in the free play of disharmonic unity there is no question who is the band leader.

Later I initiate joint conversations with Nicole and her mother linking her experience to her expressed need for attachment. This deconstructs her depression by providing it with a contextual meaning and invites significant others to take responsibility. There is a double movement between knowing and not-knowing (Larner, 2000). In voicing my own knowing, thinking, hypotheses or ‘inner conversation’ (Rober, 2005), I invite Nicole to express her thinking and meaning, as through her drawing.

At various times during the therapy I am challenged by Nicole and moved by her suffering to respond. For Levinas (2004) the ethical relation occurs at this level of sensibility and the body. This is what prompts me to think in relation to the other, for example in asking Nicole to draw her depression. There is sense in which we are both different persons through the experience. Nicole with a sense of personal identity apart from her depression, and I am better informed as a therapist to help other young persons.

Concluding Reflection

For Levinas subjectivity is a welcoming of the other as hospitality. The marvel of the idea of infinity where the person is greater than a technology or language of therapy can encompass. The other is an excess or overflow of meaning, which breaks the narrow vision of what therapy is. Face to face with an infinite other beyond our concept or comprehension we are called to be

ethical. For Levinas subjectivity is a moral event, the self is formed and knows itself only to the extent it takes responsibility for the other: “To be unable to shirk: this is the I” (TI p.245). The definition of self as concept or theory gives way to trembling and fragility in the presence of the other (Larner, 2004).

The self is formed by taking responsibility for the other, yet to do so one must already be a self, wherein lies the paradox. The relation between the private and social self is a deconstructive complexity of both/and. There is other *and* me. To be otherwise or different there must be an “I” separate from the other in me. There is you and I, but there is also a third, which is ethics or justice.

In my therapeutic work I adhere to the social constructionist idea that persons are relational beings constructed through narrative, conversation and dialogue. However I *also* believe the self is experienced as a unique, individual and integrated locus of identity or self-consciousness independent or separate from others. The self is dialogical and relational yes, but at the same time can be described as having a sense of unity, coherence and independence. This opens up *many* languages for describing the self in family therapy.

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Chapter 8: Integrative Family Therapy With Childhood Chronic Illness: An Ethics of Practice¹³

Abstract

A challenge for contemporary family therapists is negotiating differences between modern and postmodern frameworks in the practice context. Modernists espouse a systemic metaphor, use evidence-based and interventive approaches, including strategic, structural- or solution-focused techniques, and believe in the therapist's knowledge, expertise and power to influence individuals or families to change. On the other hand, postmodernists follow a social constructionist, dialogical or narrative paradigm, which identifies the main ingredient of therapy as language, conversation, understanding and the therapist's 'not knowing' stance in eliciting a person's expertise and story. Yet many practitioners adopt a middle way between these paradigm polarities, one that is less theory-driven and more pragmatic, flexible, integrative and practice-based. This is consistent with evidence-based practice and research demonstrating common factors across all therapies. The value of preserving systemic thinking in family therapy is recognised while reaching forward to a

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postmodern social constructionist and dialogical approach. The article describes this integrative stance in family therapy as paramodern based on an ethics of practice. This is illustrated by a detailed case study of integrative family therapy, which addresses anxiety, anger and sleeping issues associated with a chronic childhood illness called Perthe's disease.

Keywords: integrative, ethics of practice, paramodern, chronic childhood illness

A major challenge for family therapists today is how to negotiate differences between modern and postmodern frameworks in the practice context. On the one hand, modernists espouse a systemic metaphor, use evidence-based interventions including strategic, structural- and solution-focused techniques, and believe in the therapist's knowledge, expertise and power to influence individuals or families to change. On the other hand, postmodernists follow a social constructionist, dialogical or narrative paradigm, which identifies the main ingredient of therapy as language, conversation, understanding and the therapist's 'not knowing' stance in eliciting a person's expertise and story.

Yet many practitioners in the field position themselves somewhere *between* these polarised positions despite the theory tension. They recognise the value of preserving a systemic framework in family therapy while engaging with and reaching forward to a postmodern social constructionist and dialogical

perspective. Thus, in *The Dialogical Therapist*, Paulo Bertrando (2007) comes to the following conclusion about his practice as a systemic and dialogical therapist: ‘There is something still unresolved in this approach: the debate between modernism and postmodernism, between understanding and influencing, all the polarities my practice is inscribed into. And, I guess it is better for them to stay unresolved’ (p. 248).

Likewise, in *The Performance of Practice* Jim Wilson (2007), surveying diverse family therapy approaches — including more recently a dialogic framework — that have shaped his approach to systemic practice over three decades, comments: ‘My family therapy “tree of knowledge” no longer necessitates that one branch be higher placed and more privileged than another’ (p. 14). Wilson allows (modern) structural and (postmodern) language-based ideas to freely ‘suggest themselves’ and ‘emerge in the conversation at one stage and submerge at others’ (p. 41).

Like others in the field tired of ‘theory wars’ these authors demonstrate a pragmatic stance that deconstructs theory to straddle modern and postmodern approaches as ‘both/and’. Other theorists also propose a more integrative, flexible and practice-based description of family therapy using terms like theory flexibility (Flaskas, 2002), promiscuity (McNamee, 2004) and irreverence (Cecchin, Lane & Ray, 1993). For example, the latter suggest family therapists shift their focus from the politics of theory (taking sides in debates whether

family therapists should be interventive *or* understanding) to reflexively question the effect of their own frameworks, beliefs or prejudices on others.

Inspired by deconstructive philosophy, the author calls this ‘both/and’ stance in family therapy *paramodern*, where the prefix *para* means sitting beside *and* beyond at the same time, despite the aporia or contradiction (Larner, 1994a). As Derrida (2007) said in the last interview before his death: ‘I say contradictory things that are, we might say, in real tension; they are what construct me, make me live and will make me die’ (p. 47). Therapy, like life, is more complex than theory or language can ever express.

In what follows the author briefly describes a paramodern stance and theorises integrative family therapy as an ethics of practice. The body of the article then illustrates the theory, using a detailed study of family therapy practice, which addresses anxiety, anger and sleeping issues associated with a chronic childhood illness called Perthe’s disease.

A Paramodern Stance

As previously described, a paramodern stance positions family therapists within a modern, scientific and systemic tradition *while* they engage with a postmodern, social constructionist, dialogic or narrative framework (Larner, 1994, 2004a). This is consistent with recent trends towards integrative practice in family therapy (Vetere & Dallos, 2003), as well as efforts to construct a modern or scientific evidence base for the discipline (Stratton, 2001). Here ‘what works’ in practice is seen as more relevant than strict adherence to a

theory paradigm or position. It also fits research demonstrating that common factors like the therapeutic relationship contribute more to therapeutic change than the specific model or technique used (Fraser, 2003). What is important is not what, but *how* knowledge, expertise or therapeutic techniques are applied in the therapeutic relationship, which as the author will suggest defines an ethics of practice.

The effectiveness of integrative family therapy approaches with complex problems, for example, adolescent depression (Larner, in press a) or eating disorders using the Maudsley model (Rhodes, 2003), has attracted increasing interest from other disciplines. At the same time, family therapists have access to a range of evidence-based psychological options when working with individuals and families, including: mindfulness-based cognitive therapy (Williams, Teasdale, Segal, & Kabat-Zinn, 2007) or acceptance and commitment therapy (Harris, 2007) for depression; behavioral family interventions for child conduct issues (Dadds & Hawes, 2006); behavioural therapy for obsessive–compulsive disorder (Griffin, 2003), dialectical behavior therapy for self-harming or suicidal adolescents (Miller, Glinski, Woodbury, Mitchell, & Indik, 2002), and so on.

From a paramodern perspective such therapies are not seen as *opposed* to family therapy or dismissed as ‘modernist’ discourses, but as potentially enriching systemic or dialogical practice. Here a social constructionist, ‘not-knowing’ stance in family therapy (Anderson, 1997) can sit with the therapist’s

knowledge, expertise or power to intervene despite the tension. Peter Rober (2005) describes a similar dialogical stance in terms of the therapist's inner conversation between their experiencing and professional selves, where therapeutic knowledge and reflections become part of the dialogue with the family.

Paramodern therapists can be modern *and* postmodern, knowing *and* not knowing or interventive *and* noninterventive at the same time, using approaches and techniques that are most likely to introduce change and difference. Indeed a 'not knowing' stance can provide a relational and dialogical context for various therapeutic interventions to have currency or be effective. For example, there is some indication from the research literature that integrating systemic family therapy with cognitive therapy is effective for depressed adolescents (Larner, in press a). Yet in the author's experience, *any* therapeutic work with adolescents requires an engaging, creative and collaborative therapeutic relationship. This is essentially 'not knowing' or dialogical in the sense of providing a therapeutic space for the young person's voice to be heard.

An Ethics of Practice

A paramodern stance describes an ethics of practice, where the priority is not strict adherence to a theory position but the relation to the other. In terms of the ethical philosophy of Levinas (1969) the person is put *first* before any theory, knowledge or technology of therapy. However, unlike a postmodern or social constructionist position, this does not occlude the therapist's power to intervene

or use different therapy techniques. Rather it recognises a critical responsibility for therapists to *know* and think about what is effective in alleviating the psychological suffering of others (Larner, 2004b). As Levinas (1984) says, without modern knowledge or technology people would starve, which itself is unethical, therefore: ‘We have no option but to employ the language and concepts of Greek philosophy even in our attempts to go beyond them’ (p. 64).

An ethics of practice allows both knowing *and* not knowing, what the author calls *knowing not to know* (Larner, 2000). It does not require therapists to choose between a modern or postmodern paradigm, but to be mindful about imposing their therapeutic ideas or knowledge on others. As Derrida (1999), in explicating Levinas puts it, to be ethical is to *approach* the other with hospitality and fraternity. It concerns the welcome or ‘place offered to the stranger’ (p. 68), rather than the particular theoretical language spoken. To be ethical is to take in and be hospitable towards how others speak, whether they are colleagues speaking other therapeutic languages or clients conversing in therapy (Larner, 2003).

An ethical stance allows family therapists to access a range of therapeutic languages and techniques at once. The priority is not what knowledge we use but *how* we use it. This is integrative, not in the sense of unifying frameworks but putting theory to work in the service of others. Family therapists can move freely between different ways of thinking about therapy in *response* to the therapeutic encounter with the other. Adapting Bion’s psychoanalytic idea of

containment, the therapist takes in and *thinks* the emotional experience of the other as a gesture of hospitality (Larner, in press b). Here family therapy can be described as an ethical process that brings together (into the whole) different conversations in therapy, which is both systemic *and* dialogic.

The following case study illustrates an integrative ethics of practice with the therapist's reflections included in the text in *italics*. Names and details have been changed to protect confidentiality.

Geoffrey and the Anger Fear¹

Geoffrey is a 10-year-old boy referred for anger and depression associated with a debilitating medical condition called Perthe's disease, diagnosed 2 years previously when he started limping. This is a disease of the hip joint where the femoral head deteriorates because of insufficient blood supply to the joint. It has unknown aetiology and cure although most children recover after 2 to 5 years. Treatment includes bed rest, medication for the pain, wearing a brace or splint for 2 years and surgery, which rarely helps. Geoffrey had numerous operations including a hipbone graft. At the time of referral he had been in traction for 6 weeks, worn an external hip brace with six pins attached over 6 months, and required crutches to walk.

A major problem was recurrent nonhealing infections resulting in further hospitalisations, which required dressings twice daily. During these procedures usually done by his mother, a nurse and masseur, Geoffrey had recently become noncompliant, abusive and aggressive. The family structure consisted of

Geoffrey, his parents and a younger brother. Regarding his intellectual and social development Geoffrey was a full-term baby with normal milestones; he did well at school and made friends easily.

Initial Family Session

The parents, Sue and Bob, and Geoffrey attended the initial interview to see me and a psychiatry registrar. Discussing the effect of Geoffrey's illness on the family, Sue requested help for managing his angry outbursts during dressings:

“Geoffrey digs his heels in saying ‘I’ve had enough’, and becomes verbally abusive. They become 3-hour battles on a daily basis. I’m targeted as I do the dressings. I lose the plot when he becomes obstinate and refuses to have the dressing done. He can fly into a rage in one breath. It bounces round the family”.

The registrar strongly recommended re-examining the issue of pain relief and suggested medications. However Sue wanted help with managing the family pain management cycle: ‘It impacts on us resulting in higher stress levels. We close down on each other’. Bob wanted advice for the anger outbursts but, like Geoffrey, expressed strong reservations about counseling.

Two days later I received an angry phone call from Sue about the registrar's input as numerous specialists had already advised analgesics could not relieve Geoffrey's pain. Wondering about the difficulties of working systemically with medical colleagues, I apologised, promising to focus on family issues.

Afterwards, I reflected on the systemic tension between Geoffrey's chronic illness, the medical system, the pain management interaction cycle and anger outbursts that 'bounce round the family'. To what extent did Sue's expression of anger towards me mirror the family process? In systemic terms was there a connection between Sue's angry response and Bob's and Geoffrey's reluctance to attend therapy? I wondered if both father and son were afraid to address relationship issues in the family. Was Sue as keeper of the family problem metaphorically passing the 'bouncing ball' to me in the countertransference relationship? The challenge for me as a therapist was not to become defensive or angry but to catch the family ball of anger, to take it in and understand.

Carmel Flaskas (2005) sees emotional impasses in the therapeutic relationship as challenging therapists to be curious and think. So far, in my therapeutic relationship with Geoffrey and his family, I was mindful of the need to tread carefully and lightly, as if applying a dressing to their emotional pain. A first step was to make reparation for the registrar's gaffe, which in a strange way had exposed the family relational wound and left me wondering about the best therapeutic balm to apply.

Second Session

Two weeks later Sue and Geoffrey attended, reporting significant improvement. Geoffrey's infection had healed and his anger had subsided, with only a slight

wince as the ointment was applied. As Sue explained: ‘He understood our concerns about the effects of his pain and anger’.

As a family therapist I am often surprised when change occurs, using terms like ‘miracle’ to describe it as falling within the family’s narrative time, rather than being under the control of a technology of therapy (Larner, 1994). Yet here it followed what I perceived as a disastrous family interview! Quite apart from Geoffrey’s infection healing, it is easy to underestimate the powerful systemic effects of a therapeutic conversation with a family around a presenting problem.

Geoffrey had taken in Sue’s concerns, possibly in response to her feeling less angry towards him. Perhaps she felt more hopeful as a result of my gesture of hospitality in accepting her anger and apologising for the registrar. My response in the therapeutic encounter helped to ‘catch’ and contain the family ball of anger.

This is where family therapy can be described as an ethical process of engendering understanding and hospitality. As Bertrando (2007) describes post Milan systemic therapy, the therapist’s reflexive and curious stance is achieved through being attuned to the emotional system of the family.

Next Sue mentioned the impact of Geoffrey’s disability at school. He agreed saying: ‘I don’t like it. I sit there ... I have to watch other people do what I can’t do’. Sue reported Geoffrey had strong reservations about counselling, saying he was not going to talk to a stranger, and her husband felt the same. At

the age of 8 years Geoffrey saw a psychologist at an anxiety clinic for his fears about being in one side of the house alone and going to bed at night. This anxiety predated his illness by 2 years after he went on a 'kid's ghost walk' and was still a major problem. He was also concerned about paedophiles after a man in a car recently attempted to abduct a friend.

Geoffrey reiterated he did not want to talk to a counsellor. I said he did not *have* to talk, but picking up on the school issue wondered if he was saying 'I'm normal, I don't have a problem', and he agreed. I enquired about other times he felt scared, like being in hospital and wondered whether counselling was another situation where he was saying to mum 'Don't leave me'. Sue agreed and Geoffrey said he would attend if mum stayed in the room.

In this session I construct a child-friendly family therapy space to engage Geoffrey in therapeutic conversation (Rober, 1999). In this dialogic space I share my knowing and thinking as a therapist about Geoffrey's emotional experience. In narrative therapy terms I explore Geoffrey's self-identity in relation to his chronic illness. A possible link is suggested between Geoffrey's anxiety, fear of paedophiles, coming to counselling and being abandoned in hospital.

The following week Sue cancelled as Geoffrey was in hospital having pins in his hip removed, though he said he would attend counselling. A week later Sue cancelled again saying Geoffrey changed his mind, feeling he did not have a problem. After a month Sue rang to say Geoffrey would talk to me if

taken to McDonald's. Three days later Sue rang to say Geoffrey actually asked to talk to me about his fears.

There is significant work being done by the family outside the session concerning who owns the problem and needs counselling. Foremost in my mind is containing the family emotional pain surrounding the impact of Geoffrey's illness. As Flaskas (2007) notes, in families where there is a child with a serious disability different persons can express extreme positions of hope or hopelessness.

In the therapeutic relationship I give Geoffrey space to decide about coming to therapy, as it expresses the nub of the issue — namely questions of attachment, abandonment, identity and power. In response to the evolving family narrative my stance is flexible, curious and reflective and moves freely between different therapeutic languages in the ethical relation.

Third Session

As the session began Geoffrey asked his mother to stay in the room. Sue discussed his bedtime anxiety: 'If we put him to bed and leave him he shows sheer terror'. Geoffrey said his fears worsened following his recent hospital visit. I asked if he felt afraid on that occasion: 'I was afraid of Mum and Dad just leaving me there'. Sue explained Geoffrey was in hospital for 6 weeks about 6 months ago: 'We couldn't be there 24 hours. He asked us to promise not to leave him there'. Over the previous year Geoffrey's hospitalisations had

included a bone graft (6 weeks), infection control (6 weeks), and having pins removed (9 days), with numerous outpatient visits as well.

I asked Geoffrey to describe his fear: 'That someone is going to be there'. Sue confirmed his sleeping problem was worse since his last hospital stay; if put to bed before his parents he bangs on the wall calling for Dad. A significant factor is Sue's work in the adjoining room as a massage therapist between 6.00 and 9.30 pm over the last 5 years. Bob lets Geoffrey fall asleep on the lounge, carrying him to bed after 9.30 pm. Sue referred to him as the nurturer in the family.

Thinking from a behavioural and narrative therapy framework at once (*yes it is possible*), I commented feeding fears can reinforce or strengthen them and Sue replied: 'Bob feeds the fears big time. He always supports Geoffrey, doesn't listen to me, he minimises it saying he will grow out of it. I didn't tell him about coming to counselling this time'. Next Sue said: 'We don't talk to each other, for the last 3 years, that's how our marriage is. That half hour between finishing my work at 9.30pm and going to bed was sacred space and now it's been taken'.

Wow! Sue's statement revealed a wider relational context for Geoffrey's anger/ fear than I had imagined. Quite apart from attachment issues and the trauma of Geoffrey's chronic illness and hospital experience there were serious parenting and marital issues. From a structural family therapy perspective the strong coalition between Bob and Geoffrey against Sue muddied child-parent

boundaries and complicated parenting and discipline.³ Or, from a Bowen theory perspective, Geoffrey's anger and anxiety reflected his triangulation within the parenting and couple system.

Perhaps Geoffrey's anger fear acted as a nodal point for the family system to coalesce, at the same time as providing its breaking or stress point. The relational issues between Sue and Bob were enacted in Geoffrey's wince of pain and anger during the dressings and his anxiety about being alone in the house and sleeping. No wonder Bob was reluctant to attend counselling with his marriage on the line, and Geoffrey had real grounds to fear being abandoned by parents caught up in ongoing conflict and living separate lives.

I wondered aloud if Geoffrey's fear reaction was an attempt to regain power and control over his broken life and whether there might be another way to achieve this. I then asked: 'Who has the most power in this situation?' Sue said: 'If Bob is around he will step in when I say no to Geoffrey 100% of the time, it's always been the case'. I conjectured having too much power could increase Geoffrey's insecurity and fear. Sue replied: 'Bob will only be firm if pushed to the limit by Geoffrey then he loses it and gets angry'. Geoffrey agreed: 'Really angry'. Sue then backs off and leaves Bob to work it out. I asked if there was another possible solution here. Sue suggested: 'I could back out and let Bob deal with it all'.

I am developing a systemic hypothesis that links Geoffrey's anger/fear in relation to his chronic illness, Bob's anger and Sue's disempowerment as a

parent and complications for the couple relationship. Thinking in a variety of frameworks takes into account the complexity of practice and interplay between these various factors.

I invite Geoffrey to consider the relational meaning of his pain/anger/fear/anxiety and the couple to rethink their parenting and relationship issues. As Bion describes the idea of containment, the therapist holds emotional meaning for the family so it can be thought (Larner, in press b).

As the session ends I asked Geoffrey if he was ready to see me alone and he replied: 'Not next time, the time after, mum outside'.

Fourth Session

Sue and Geoffrey attended 2 weeks later, the latter again expressing anxiety about his mother leaving the room. As this is a pivotal session I include a verbatim presentation of significant sections.

Sue: Geoffrey falls asleep on the couch every night until Bob carries him to bed.

Geoffrey: I don't, I'm awake. I lie with my eyes closed while dad watches TV. When mum comes out dad goes to bed, I do too usually around ten.

Therapist: What does dad think about this arrangement?

Geoffrey: Dad doesn't seem to mind, on weekends I go to bed whenever I want.

Therapist: Do you want it to be different or are you happy to continue the same way?

Geoffrey: I don't mind if it keeps going on.

Therapist: You don't want to change the situation?

My systemic question introduces the possibility of difference and invites Geoffrey to choose between things staying the same or changing. I am curious about him choosing the former.

Geoffrey: I would if I had to.

Therapist: What do you mean, if you had to?

Geoffrey: Mum and Dad forcing me not to stay up with them and go to bed.

Therapist: What would happen if they did that?

Geoffrey: I wouldn't be happy.

Therapist: Would they do it?

Geoffrey: I don't know

Therapist: Have they ever done something like that?

Geoffrey: No.

Therapist: What if Dad did it while Mum is working?

Geoffrey: He did it once but I came out.

Sue: It would be very loud, calling out, crying, he would hammer on the wall, become hysterical. I couldn't risk it while a client is there, on the weekend it may be a possibility.

Geoffrey: I get to stay up with Mum on the weekends

My questions take up Geoffrey's assertion he would only change if his parents

forced the issue, unravelling this scenario. His last statement suggests anxiety about sleeping is linked to attachment concerns and bonding time with his mother.

Sue described an altercation with Bob after our last session where he ridiculed her in front of the children, put his hand on her face in anger and she spat at him.

Sue: We didn't speak for 4 days. The kids tried hard to get us to speak and be civil. It was very nasty. It's never been physical before.

Therapist: Is there any significance to this occurring after our last session?

I am curious whether our discussion in the previous session about Bob's support of Geoffrey and anger towards Sue has made a difference to the couple relationship?

Sue: Me speaking out loud what I know to be true, Bob not supporting me with the kids.

Therapist: Are you on speaking terms now?

Sue: Bob said he would try to walk away and not interfere. He doesn't like the way I speak to the kids, says I'm too loud and bossy.

Therapist: What does Bob think about counselling?

[Sue said he now supports it.]

Therapist: Would he come?

Sue: He might.

In family therapy one is often surprised by what happens, which illustrates the need for therapists to be flexible and open. My thought is to invite Bob and Sue along to discuss their parenting and relationship issues.

I asked Geoffrey for his thoughts about what happened.

Geoffrey: I didn't like it and never want them to do it again. I was scared they might break up.

Sue: Both kids checked out if we had.

Therapist (to Geoffrey): Do you have any influence in this situation?

Sue's statement supports my hypothesis about Geoffrey's added fear of abandonment by separating parents. I am thinking his sleeping problem is seriously stressing the marital system and any change could relieve some pressure. This systemic thinking leads to a rather first order strategic question and intervention about power and influence.

Geoffrey: I don't know.

Therapist: What about sorting the bed thing out, would it help the situation?

Geoffrey (hesitantly): Yeah.

Therapist: Are you willing to experiment going to bed one night per week a little earlier?

In the therapeutic conversation my stance is curious and systemic, but nonetheless powerful and directive in exploring the question of influence. My question to Geoffrey borrows from Madanes' (1981) strategic use of

behavioural tasks to help families experiment with patterns of interaction around the presenting problem.

Nonetheless, therapeutic engagement with Geoffrey was a gradual process that occurred on his terms and according to his narrative time. Jumping in too quickly with an evidence-based technique for anxiety would have prevented his participation and cooperation by adding to his realistic fears about being abandoned. Giving Geoffrey the space to define his view of the problem allowed him to come up with an alternative solution.

Geoffrey: I really wouldn't want to. I don't like going to bed early and I'd be scared.

Therapist: Imagine if one night you did go to bed early, what time would that be?

Geoffrey: 9 pm.

Therapist: What would you be thinking about in bed?

Geoffrey: There would be people in the house besides Mum, Dad, my brother and the client.

Therapist: What would be your worst fear?

Geoffrey: Someone is trying to kill us.

Therapist: But you don't think that if Mum and Dad are in bed?

Geoffrey: I feel safe.

Therapist: Strange, I would have thought you might feel safer when Mum and Dad are up and about the house.

Geoffrey: I'm not meant to knock on the wall when Mum is doing massages.

Dad is on the other side of the house.

In terms of solution-focused therapy I invite Geoffrey to imagine the problem is dissolved in another possible future. Then I explore beliefs that contribute to anxiety and fear from a cognitive therapy perspective. This is what I mean by moving freely between different therapies as an ethics of practice, which is integrative and at once systemic and dialogic in engaging others in the therapeutic conversation.

During this conversation I have asked Geoffrey to draw a detailed map of his house to show me where his fear is strongest. In narrative therapy terms this drawing task externalises the problem and enlists Geoffrey as an ally against anxiety by locating its dimensions in physical, temporal and psychological space.

Therapist: Again tell me what your worst fear would be?

Geoffrey: Someone breaks in and I might hear them.

Sue: Ask him about the paedophile.

Geoffrey said he became scared of paedophiles while waiting for the school bus after a friend was chased by a man. Such reports are often in the local media. I direct the conversation back to bedtime and ask Sue.

Therapist: If Geoffrey heard someone breaking in could he bang on the wall even if there was a client?

Geoffrey: Dad doesn't come in if I do it all the time.

Therapist: The boy who cried wolf, know it?

Geoffrey: There was a little boy who knocked on the wall to get his dad to come in. One night he went to sleep and woke with a noise.

Aesop's fable engages Geoffrey's imagination as he extends the story to his own situation in a playful manner, showing he is involved in the therapeutic conversation. In systemic terms the metaphor invites Geoffrey to draw a distinction between real and present danger and fear about fear in response to the family issues.

Therapist: What happened?

Geoffrey: The father didn't believe him when he knocked on the wall.

I comment on the boy's power in this story and Sue said: 'You need to separate fear and overwhelming fear. I think the power play is very bad'.

Sue has begun to think with me in a systemic way, drawing a difference between 'fear' and 'overwhelming fear' and arguing a moral position on children's 'power play'. This is in response to me as a therapist attempting to understand and think her emotional experience, which as I have suggested enacts an ethic of hospitality.

In the therapeutic conversation my 'second-order' curious, not-knowing and systemic stance co-exists with a 'first-order' structural and strategic intervention that directly supports Sue's parental role.

Geoffrey: I don't know what power play is.

Therapist: Like the boy who cried wolf, you're very powerful in saying when you go to bed.

Geoffrey: It's like having power over someone else. I get to stay up late and other people like me don't.

Therapist: Have you ever thought of sharing your power, say by going to bed earlier one night a week?

Using the parable of the wolf story Geoffrey begins to rethink his fear. My strategic question about power-sharing acknowledges fear is important to Geoffrey's survival and change should occur in his own time. His anger/fear includes an 'overwhelming fear' of family breakdown. This references my thought about his symptom acting as a nodal point for the family system: Is change possible without the family structure collapsing?

Geoffrey: When will it have to start? This week ... it would have to be tonight, Friday is the weekend. Can we start Tuesday?

Who could have predicted this response towards change? Perhaps it is one of the magical or 'miracle' moments we sometimes experience in therapy (Larner, 1994b).

Sue agreed but would like to see it in writing.

Geoffrey: Mum signs it and I sign it — the contract.

Sue mentions they have used contracts before. I suggest Bob witness it.

This involves Bob in the behavioural experiment; in narrative therapy terms it engages him as an outside witness to change.

Enthusiastically Geoffrey said he would write it out now:

‘I, Geoffrey agree to go to bed on Tuesday nights at 9 pm even if Dad is not in bed and I get \$5 for a pack of pokemon cards. Signed Geoffrey’.

I asked if there could be something for Mum and Dad out of this.

Sue exclaimed: We get a free night.

Geoffrey: Next time I come here we go for 2 nights a week.

I suggested Sue and Bob could work on their relationship.

Geoffrey: You’ve already promised not to split up.

Sue: We could have something for Bob and me, when time is so short. Perhaps a packet of scorched almonds.

Geoffrey: You could get a sticky date pudding.

Sue: You’re a brave boy.

Geoffrey: Thank you.

On leaving Sue thanked me: ‘It was a lot easier than I thought it would be’.

Follow-Up

The following day Sue dropped a note in saying Geoffrey could not wait until Tuesday to earn five dollars for his cards and went to bed at 9 pm last night without a problem. He renegotiated the contract to receive \$5 for going to bed 1 night a week, \$7 for 2 nights and \$10 for 3 nights, with no further payments. I arranged a follow-up appointment in 3 weeks.

I was surprised to see Geoffrey and Bob in the waiting room without Sue. Bob said Geoffrey had gone to sleep in his own bed without trouble at 9 pm (sometimes earlier) every night over the last 3 weeks. Bob commented: 'No problems during the storm, he just reads till he falls asleep. I play the guitar. He has been going to bed every night since he was last here, no knocking on the wall or saying he's scared. Sue and I are going to the Blue Mountains this weekend for our 16th wedding anniversary. A milestone, it's been a heavy couple of years'. I asked what had helped most and Geoffrey replied: 'If I went to bed 4 nights in a row I was cured and the contract was finished'. A phone call 2 months later confirmed these changes.

Writing this case study up some 8 years later, I rang the mother, curious how things had progressed. Geoffrey was now 18 years old, well-adjusted and about to attend university. Concerning his illness Sue said: 'He has had five operations and has a limp, but won't have problems until he is 50 years when he will get secondary arthritis. It doesn't affect his lifestyle'. I asked what happened following therapy and Sue replied: 'Once we did the bargain thing he went back to normal, his behaviour stretched more. The fear was no longer a problem'. She saw his problem as 'the fear and the power struggle between us'.

I asked what she found most helpful from therapy and she replied: 'It was very helpful having a mediator. Once the contract was done it was good. We used it again. We still use it to negotiate things'. Sue then said: 'When the fear

went it was relief. He realised he could contribute in a more positive way'. Sue said her relationship with Bob had also improved.

Conclusion

This article has described integrative family therapy as an ethics of practice. This was illustrated by a detailed case study, which addressed a complex overlay of medical, emotional, psychological, relational and family issues associated with chronic childhood illness. An ethical stance was defined as hospitality towards different therapeutic languages, which is inclusive of modern and postmodern approaches as *paramodern*.

This is one way of theorising family therapy and undoubtedly there are many others equally interesting and valuable, some of which the author has referenced. Then again, the possibility of such difference or theory diversity *is* the thesis of an integrative ethics of practice. As often demonstrated by case studies, no matter how family therapists think therapy, what happens in practice often has a life of its own that surprises us.

Note

Glenn Larner is a co-editor of ANZJFT and in 2008 received the journal's special award for distinguished contribution to family therapy.

Endnotes

1 *Anger fear* is the author's construct to describe the intricate relation between these emotions. In Geoffrey's case, fear in relation to his medical condition,

frequent hospitalisations and the possibility of family breakdown provided the background for his anger.

2. Shapiro (2003) used systemic ideas in the context of psychoanalytic therapy with an adolescent suffering paralysing psychosomatic chronic pain: 'The analyst must negotiate the intrapsychic, familial and systemic conflicts immediately, starting with the first session' (p. 549). Shapiro worked separately with the girl and with her parents on a weekly basis becoming aware how her illness 'buffered the marital discord' (p. 551). As the girl improved the mother became more depressed.

3. A qualitative research study by Tsampanli-Kitsara and Kounenou (2004) found structural family issues like parental splitting, the child's involvement in marital conflict and boundary or rule ambiguity characterised families with a child suffering from a chronic illness like diabetes.

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Chapter 9: Integrating Family Therapy in Adolescent Depression: an Ethical Stance¹⁴

Abstract

Adolescent depression particularly where suicidal behavior is involved is a complex and pressing mental health problem demanding for families, therapists and services alike. The paper reviews the evidence-based literature for adolescent depression including family therapy approaches. It suggests an integrative treatment approach that includes individual psychological treatment like CBT, medication where required and a family therapy intervention is supported by the literature. The focus of the latter is psychoeducation, building resilience and hope, enhancing communication, reducing relational conflict between parents and adolescents and addressing attachment and relationship issues. A systemic framework for integrating family therapy in the evidence-based treatment of adolescent depression is described. This is based on an ethic of hospitality towards different languages of therapy, which is illustrated by a detailed example from family therapy practice.

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Introduction

Adolescent depression is a complex and pressing mental health problem particularly where suicidal behavior is involved. Epidemiological research gives a prevalence between 4-8% with depression a significant risk factor in youth suicide (TADS, 2007; Rey et al 2001; Jacobsen et al 2008; Fortune and Clarkson, 2006; Bridge et al, 2006; Flisher, 1999). As Bart Simpson said at a Gothic rock concert in the Simpson's episode *Homerpalooza*: "Making teenagers depressed is like shooting fish in a barrel". Unfortunately helping them to get better particularly where suicidal behavior is involved is not so easy.

It is hard for therapists and teams not to be caught up in a sense of emergency and panic surrounding the presentation of a depressed and suicidal young person, particularly where there are high levels of risk. This can be demanding for families, therapists and services alike, especially where the presentation is complicated by comorbid problems like substance abuse and disrupted family or peer relationships.

Carmel Flaskas (2007a) has aptly captured its impact on the systems involved: "The levels of despair and anxiety and anger skyrocket with each new act of horror, and the positioning of blame intensifies as the fear of a dead young woman burns through the system. 'The system' by now includes the young person, the parent/s, the family, the group of friends, the school counsellor and teachers, the treating psychiatrist, the staff of the ward where she was hospitalized - and in the adolescent mental health team, the primary

therapist/s and everyone on the team who has been caught up in one crisis or another on intake (p.32)”.

How therapists and teams manage depressed adolescents in crisis can affect staff morale, burnout and effective teamwork; mirroring the family process therapists can feel incompetent, powerless and hopeless. Here family therapists can play an important role in helping teams to contain systemic anxiety, responsibility and blame and establish a healthy balance between a sense of hope and hopelessness (Flaskas, 2007b). And as Fortune and Clarkson (2006) conclude child and adolescent mental health services should offer young people and their families not just crisis intervention but hope. Or as Pentecost and McNab (2007) suggest “keeping hope alive” is a crucial aspect of working systemically with depressed young persons and their families.

Adolescent depression has a complex clinical presentation that impacts several domains at once (biological, cognitive, family, etc.), meaning no single treatment approach will be effective in all cases (Harrington and Dubicka, 2002). As we shall see the evidence-based literature for adolescent depression provides some support for an integrative family therapy approach. At the very least it suggests good clinical practice involves the family in treatment especially to help contain suicidal risk (Bickerton et al 2007). As a clinical psychology colleague specializing in cognitive therapy recently said to me: “You can’t do this kind of work without seeing the families”. Likewise a recent U.K. review of child and adolescent mental health services concluded: “Twenty

years later a CAMH service without systemic/family therapists would be unimaginable...In practice settings family therapy thrives alongside cognitive behavioral therapy, psychodynamic therapy, group work and play therapy (Cottrell and Kraam, 2005, p.3)".

This article makes a case for integrating family therapy as part of a multidisciplinary and multi-modal treatment approach to adolescent depression. It builds on the author's previous work integrating family therapy in CAMHS based on an ethic of hospitality towards different discourses of therapy (Larner, 2003). This described combining individual sessions using cognitive, narrative and art therapy with systemic family therapy, to help a depressed suicidal adolescent girl break free of cultural and family expectations and find her own voice and identity.

First the paper examines the significant role of family and peer environment in adolescent depression; then it reviews the evidence-based treatment literature including family therapy approaches. Next it presents a systemic approach to integration based on an ethical stance, which brings different therapeutic approaches and languages into connection and dialogue with each other. This is illustrated by a detailed practice narrative of a depressed suicidal adolescent and his family, a story of resilience and hope in the face of adversity and despair.

Family environment and adolescent depression

There is extensive empirical research showing what happens in families contributes to the development, maintenance and course of adolescent depression (Fortune and Hawton, 2005; Diamond et al 2003; Nichols and Scwartz, 2004; Kolko, 2000; Kaslow et al. 1994). This literature consistently demonstrates the significant role of adverse family environment factors including: physical and sexual abuse, neglect, attachment failure, psychiatric illness in a parent (particularly maternal depression), family conflict, stress and breakdown, a poor parent-adolescent relationship and ineffective parenting.

Thus confirming the clinical experience of many therapists, a German study of 1035 adolescents found having a depressed mother and perceived poor attachment to parents was significantly associated with depression and suicidal ideation (Essau, 2004). In high school students, family stress, separation and remarriage increase suicidal risk while family cohesiveness alleviates it (Rubinstein, 1998). For younger adolescents depressive symptoms increase where there is relational conflict with mothers around autonomy (Allen et al; 2006). A longitudinal study of family risk factors in adolescent depression found an association with family structure and cohesion: where adolescents have a positive relationship with parents who are perceived as warm and caring they are less likely to report depression (Cuffe et al; 2005).

As Shochet and Dadds (1997) conclude: “Thus, the quality of parent-adolescent relationships and the presence of family conflict are reliable predictors of adolescent depression (p.308)”. On the other hand adolescent

depression can significantly impact family relationships and harmony (Tan and Rey, 2005). Depressed teenagers are more likely to be perceived as ‘difficult’ by their parents and contribute to parenting stress. If you have a depressed adolescent you are more likely to have a depressed mother and clinicians need to investigate its effects on the rest of the family.

Given the significant contribution of family environment in adolescent depression, family therapy can play a significant role in its prevention and treatment. It can address crucial aspects of family life like communication, parenting issues, adolescent-parent relational conflict, psychiatric illness in a parent, high levels of expressed emotion, attachment issues and relationship breakdown. Most importantly it can enhance family cohesion, adaptability and resilience and enlist family resources to help contain depressed young persons in times of crisis. As Bickerton et al. (2007) show a systemic family intervention model with high risk suicidal adolescents helps to prevent hospitalization.

Peer Influences, Technology and Bullying

Even where family environment is benign, disrupted or conflicted peer relationships can act as a powerful trigger for adolescent depression. In the virtual world of internet chatting, mobile phones and *My Space*, adolescents are increasingly vulnerable to gossip, malignment, relational conflict and exclusion from social networks. Thus a recent U.S. survey of 2342 high school students

found bullying both for victims and perpetrators is a significant risk factor for adolescent depression and suicidal ideation and attempts (Klomec et al; 2007).

The example comes to mind of a 16 year old depressed boy who attempted to hang himself after his girlfriend and best friend went to a dance without him despite his pleas. Over several months the boy had spent hours every night chatting on mobile and internet, caught up in a flurry of gossip and vindictive allegations, which the parents with whom the boy had a very positive relationship had no idea about. This night the boy sent a text to his friend threatening to kill himself and after receiving the heartless response “Do It” very nearly complied.

Evidence-based therapy for adolescent depression

In this section I review current evidence-based treatments for adolescent depression, which provides a context for an integrative family therapy approach. Overall the literature supports cognitive-behavioral therapy (CBT), interpersonal therapy (IPT) and a cautious use of pharmacotherapy as first-line evidence-based interventions (David-Ferdon and Kaslow, 2008; TADS, 2007; Allen et. al., 2006; Miller et al., 2002; Hamrin and Pachler, 2005; Chan, 2005; Cottrell and Kraam, 2005). While evidence for the effectiveness of family therapy with adolescent depression is limited it is encouraging. As Liddle and Rowe (2004) concluded: “Thus the few studies that have been conducted on family-based interventions provide limited support for its efficacy with depressed children and adolescents (p.402)”.

That said, the research into the treatment of adolescent depression is still formative showing somewhat conflicting results. Some studies suggest adolescent depression is best helped by a combination of medication and a psychological treatment like CBT or ITP and that adding a family treatment component to the package enhances treatment efficacy. For example, the recent major *Treatment for Adolescents with Depression Study* (TADS, 2007) found a combination of CBT and medication to be the most effective treatment for adolescent depression, particularly where there is suicidal ideation. In this study there was a strong family treatment component consisting of psychoeducation, family problem solving, addressing parent-adolescent issues and family conflict and managing negative affect.

On the other hand the UK Adolescent Depression Antidepressant and Psychotherapy Trial failed to corroborate the advantage of combining CBT and medication treatment over the use of antidepressants alone (Dubicka and Wilkinson, 2007). Here Hazel (2007) argues that depressed adolescents can be successfully treated exclusively with SSRI's. Nonetheless a recent major meta-analytic study found modest treatment effects of psychotherapy for adolescent depression (Weisz et. al., 2006). Non cognitive behavioral approaches were found to be as robust as cognitive therapy, with the study concluding that psychotherapy is an effective alternative to the use of antidepressant medication. Like TADS (2007) it suggested one treatment be used to complement the other.

A recent comprehensive review of evidence-based psychosocial treatments for child and adolescent depression by David-Ferdon and Kaslow, (2008) concluded both CBT and IPT are efficacious in alleviating depression in adolescents. However these authors note “no single intervention has emerged as the most beneficial” (p.98) and see research as formative. Citing the attachment based family-systems approach of Diamond and colleagues (discussed below) as promising, they recommend further research into the efficacy of family therapy for depressed youth as a priority for the field. Parental and family involvement in treatment is recommended as best practice, particularly where cultural factors are involved.

This is consistent with current NICE (2005) guidelines for treating moderate to severe depression in young people, due for review in September 2009, which identify short-term family therapy as a first line treatment for moderate to severe depression in children and adolescents. At the very least a supportive collaborative relationship with families and parental involvement in treatment is recommended. Likewise the recent *American Academy of Child and Adolescent Psychiatry Practice Parameter* (2007) for treating child and adolescent depression sees family involvement in treatment as essential: “Even in the absence of formal family therapy, it is virtually impossible to successfully treat a child or adolescent patient without the close involvement of parents” (p.1510). Particularly where there is severe depression and complicating factors

like suicidal risk a multimodal treatment approach to clinical practice is indicated. **E**

Evidence for family therapy approaches

Cottrell's (2003) review of outcome studies for family therapy in child and adolescent depression provides a good introduction to the evidence-based literature in this area. This suggested family therapy complements CBT treatment of depressed young people, particularly in helping to prevent relapse after the acute stage of treatment. One of the few randomized controlled trials of family therapy for depression in young people by Brent et al (1997) compared CBT, supportive psychotherapy and systemic behavioral family therapy. While CBT was more efficacious in reducing depressive symptoms, at one and two year follow up all three treatments had helped adolescents to reduce suicidality and recover from depression.

In a subsequent study Brent et al (1999) found severely depressed adolescents living in problem families required family treatment to prevent relapse. They suggested family therapy to address family conflict is a helpful intervention *after* symptom relief in the acute phase of depression is treated with CBT or pharmacotherapy. A related study by Kolko et al (2000) found CBT most effective during the acute stage of treatment; however after 2 years family therapy produced significant changes in family conflict and parent-adolescent relationships. In a clinical trial for 107 adolescents with major depressive disorder, Birmaher et al (2000) found no significant difference in outcome at 2

years between CBT, family therapy and supportive therapy. As expected increased parent-child conflict predicted depressive relapse.

Family Psychoeducation Programs

A pilot study of 41 depressed adolescents by Sanford et. al. (2006) demonstrated preliminary evidence for the effectiveness of adjunctive family psychoeducation in the treatment of adolescent depression using individual or group counselling and/or medication. The program consisted of 12 90 minute sessions in the home addressing family communication, relational conflict, problem solving and management of crises and relapse. This helped the adolescent's social functioning and relationships with parents, which both affect the course of the disorder. However as the authors note further research is required before the results can be generalized.

Miklowitz et. al (2000) have developed a behavioral family treatment approach for bipolar disorder in children and adolescents called *Family Focused Therapy* (FFT). This uses 4 modules to assess family milieu, provide psychoeducation about bipolar disorder, enhance communication and teach problem-solving skills. A randomized controlled trial compared FFT to routine crisis management of adolescent bipolar disorder finding it resulted in a lower rate of relapse. The most dramatic improvement occurred in adolescents living in families with high levels of expressed emotion. In a subsequent two-year randomized trial Miklowitz et. al. (2008) found FFT was effective in stabilizing bipolar symptoms in adolescents when combined with pharmacotherapy.

A multimodal approach that includes family psychoeducation, individual therapy and pharmacotherapy is recommended as best practice for psychiatrists treating bipolar disorder in children and adolescents (James and Javaloyes, 2001). It is effective in helping young people with bipolar or mood disorders as an adjunct to other treatments (Fristad et al 2003).

Attachment-Based Family Therapy

Diamond et al (2003) have developed a brief manualized attachment-based family therapy (ABFT) for depressed adolescents with preliminary research suggesting its effectiveness. Adolescent depression is seen primarily as a failure of attachment, and based in family relational conflict and difficulties negotiating autonomy from parents. The therapist engages with the young person in order to diffuse interpersonal hostility, helps parents to acknowledge and apologize for relational ruptures and promotes independent activities for the young person such as improving school performance and attendance, finding a job and social activities.

This is an important clinical intervention for adolescent depression that mobilizes a crucial ethical and relational response. As the authors note: “When a rejecting adolescent becomes vulnerable, an angry parent becomes empathic. When a blaming parent apologizes, a defensive adolescent accepts more responsibility (p.116)”. To date ABFT has empirical support from one randomized clinical trial with more studies planned to address comorbid problems such as psychosis and substance abuse.

In a subsequent study Diamond et al (2007) demonstrated ABFT has a unique manualized approach that differentiates it from other treatments for clinically depressed youth such as CBT and multidimensional family therapy. This validated two stages of its treatment, namely addressing vulnerable affect and attachment ruptures and promoting adolescent autonomy and family harmony. In a further randomized clinical trial Moran and Diamond (2008) demonstrated systemic attachment-based interventions, where therapists show empathy and positive regard for parents, helps to reduce parental negativity towards their depressed adolescent.

Systemic Family Therapy

A recent clinical trial by Trowell et. al. (2007) of 72 young persons aged 9-15 years in London, Athens and Helsinki found both individual therapy and systemic family therapy to be highly effective in reducing moderate to severe depression in children and adolescents. As the authors note this study was limited by a small sample size spread across different countries and the absence of an untreated control group.

The integrative treatment approach was previously described by Campbell et al. (2003) in their naturalistic *post-hoc* study of systemic family therapy with depressed youth, which provides an excellent model for qualitative research in this area. Analysis of 150 videotaped sessions with twelve families over one year identified fifty nine ‘significant moments’ of successful therapy, which were reduced to a dozen or so major themes: addressing safety and risk,

keeping hope alive, staying connected in the therapy relationship, reframing depression in relational terms, actively involving fathers, reclaiming parenting, hearing the child's voice, re-editing fixed narratives and building networks.

These authors provide several excellent tips for family therapists working with childhood depression such as: sit with despair while keeping hope alive, work with the child's wider network, differentiate child and adult sadness, identify responsibility for solving problems, use a diverse range of theory and therapy approaches and work within a limited number of sessions.

Integrating family therapy

To summarize the evidence-based literature provides some support for a multimodal and multidisciplinary approach to adolescent depression, one which combines an individual psychological treatment like CBT or ITP with medication where required and includes a family based intervention. The latter focuses on psychoeducation, helps families to manage depression and contain suicidal risk and builds family resilience, hope, communication, problem solving and relationships. There is preliminary evidence that attachment-based family therapy, which addresses relational breakdown and parent-adolescent conflict ameliorates adolescent depression in its own right.

As a senior clinical psychologist within CAMHS this evidence-based treatment parameter certainly gels with my clinical practice and the family-inclusive approach of my colleagues. Though as the latter would testify, it is often difficult to engage depressed unmotivated adolescents in a structured or

manualized CBT program. A flexible, creative, collaborative and adolescent-friendly approach is usually required in the context of an ongoing therapeutic relationship that gives priority to engagement and employs a range of techniques such as mindfulness, art, writing, therapeutic conversation and narrative therapy (Larner, 2003).

An important question for a family therapist is *how* to integrate diverse and non-systemic treatment approaches within systemic, social constructionist or narrative thinking and practice? Over a decade ago Lebow (1997) documented an integrative revolution that combined concepts and methods across different models of individual and family therapy. A plethora of fruitful integrative family therapy approaches have since emerged (e.g. McDaniel et al., 2001), such as the developing literature combining dialectical behavior therapy and family therapy for suicidal adolescents (Miller et al. 2002; Woodbury et al. 2002).

The integrative movement had historical roots in a postmodern zeitgeist of theory and model diversity, the pragmatic response of practitioners to evidence-based practice and meta-analytic research showing ‘common factors’ like empathy, hope and the therapeutic relationship contribute more to change than therapy technique. As Nichols and Schwartz (2004) put it, integration in family therapy is based on ‘respect for the multiplicity of truth’ and recognition of a ‘complex system of biological, psychological and social influences’, which means no one school or model has a monopoly on clinical effectiveness (p.348).

An integrative model is distinct from ‘eclecticism’, which pragmatically mixes techniques purely on the basis of ‘what works for whom’. Integration in family therapy melds the theory and practices of two or more schools of therapy within a broad systemic or social constructionist approach. As Vetere and Dallos (2003) note a systemic framework is “ideally suited to help both integrative projects and attempts at rapprochement (p.15)”. Likewise for Bertrando (2005) a systemic, pluralistic and irreverent stance towards theory enables family therapists to integrate a wide range of clinical practice and experience. Or as Sheila McNamee (2005) says: “Therapy as social construction concerns itself with an ethical obligation to coordinate disparate logics or discourses (p.81)”.

In the following section I describe a systemic framework based on an ethical stance, which integrates modern and postmodern languages of therapy in the evidence-based treatment of adolescent depression.

Integration as an ethical stance

I define integration as an *ethical* capacity to work systemically within and across different therapy languages and conversations at once. This is not proposing another brand or model of integrative family therapy (Eisler, 2007), as much as an overall philosophy of integration, which can be applied to the treatment of adolescent depression or any other psychological issue. This allows the flexibility to integrate evidence-supported approaches as the research

develops in contributing to a systemic science of family therapy (Larner, 2004a).

The ethical stance involved is a gesture of hospitality towards the language of the other. Following Levinas (1969) this puts the relational other *first* before any theory, knowledge, approach or model of therapy (Larner, 2004b). Thus expounding the ethical philosophy of his colleague, Derrida (1999) says: “discourse, justice, ethical uprightness have to do first of all with welcoming (p.35)”. Likewise the theory that defines integration here is an *ethical relation* to the other, which welcomes different ways of languaging therapy.

The radical suggestion is to be integrative in this ethical sense of welcoming what is different or other *is* to be systemic in family therapy. It is to be welcoming to the stranger or foreigner, those who do not speak its familiar or systemic discourse. Paradoxically to be systemic is to be open to what is *not* family therapy. Systemic family therapy naturally welcomes and brings together disparate perspectives, voices, languages and conversations in this ethical way.

Thus the word ‘systemic’ derives from Latin and Greek words meaning “to place together” (Rosenblatt 1994), while ‘integrate’ comes from the Latin *integrare* meaning to ‘make whole’ (Australian Pocket Oxford Dictionary). In this sense to be integrative *is* systemic and vice-versa; it is to consider all voices in the conversation about what works or is helpful in therapy. As I have put it previously: “In a spirit of hospitality, family therapy brings one part of the

whole into conversation or dialogue with the other...Family therapy *is* the wider understanding, the relational movement towards the other, whether at the level of the personal, the theoretical or the political. It opens up, not shuts down, borders (Larner, 2003, p.212)”.

Application to adolescent depression

Applied to adolescent depression, the suggestion is family therapy enacts a systemic process of being hospitable towards the other across many levels. This includes work with individuals, families and colleagues as well as between different theories and discourses of therapy. This is a dialogic process of bringing together inner and outer conversations of the therapist (Rober, 2005) in order to form an integrative link with the narrative of the young person, family and wider system of involved parties, including colleagues, the team, hospital workers, private therapists, school, staff specialist etc.

The analogy that comes to mind is the *matryoshka* or Russian doll, where one figure/conversation nests inside the other. One doll is individual therapy where adolescents have the potential to develop a more integrated self through the therapeutic relationship, the use of cognitive therapy approaches, art and story etc. This builds coherence in helping the young person to understand and manage their depression. This is nested within another doll of systemic conversation with the family, which has a psycho education focus and contributes to a narrative of meaning, hope and relational understanding.

The integrative process extends to other dolls such as conversations with colleagues, dialogue at the team and service level, which as Flaskas (2007a) indicates above helps to build hope at a systemic level. As well there are integrating conversations involving wider systems of care involved with the depressed young person and their family (hospital, school, welfare), and so on. What enables the integrative link is an ethic of hospitality towards the language of the other. For example, this allows a conversation between family therapists and their non-systemic colleagues about different forms of therapeutic speaking and knowing.

Dilemmas of an ethical stance

Of course there are theory tensions and practice dilemmas associated with an ethical stance of integration, such as the temptation or pressure to compromise a systemic understanding in favor of non-systemic languages and interventions. Elsewhere I have described strategies for systemic practitioners to negotiate working with modernist languages in a child and adolescent mental health service from a stance of hospitality (Larner, 2003). As a systemic family therapist, I invite dialogue and form relational links with colleagues coming from other therapeutic traditions on the basis of mutual understanding and respect. This gesture of hospitality is more likely to be reciprocated and open up dialogue about systemic and narrative approaches to therapy.

My integrative approach has been to work within the modern discourses of psychiatry, pharmacotherapy and CBT, risk assessment and crisis management

etc., *while* working from a postmodern, social constructionist, systemic or narrative framework (Larner, 2003). I call this a *paramodern* or both/and stance of 'knowing not to know' (Larner, 1994; 2000), which like Cecchin et al's (1993) notion of *irreverence* tolerates polarities. This involves being curious, playful, and reflexive while moving freely between modern and postmodern therapy approaches.

The following vignette illustrates integrating family therapy as an ethical practice in working with adolescent depression and suicidality.

Practice Illustration: Tom

Tom is a 17 year old depressed adolescent who presented to the local hospital with his father after severely cutting his arms with a razor. Interviewing Tom and his father with the adolescent psychiatrist, I hear about his history of depression over the previous year and an attachment rupture with his mother from an early age, who also suffers depression and lives separately from the family with minimal contact between them. The aim of the assessment is to determine Tom's suicidal risk, whether hospitalization is required and formulate a provisional diagnosis and management plan, which includes his private therapist currently on holidays.

In the interview break my colleague and I agree Tom's denial of suicidal ideas or previous self harm doesn't jell with the seriousness of his current presentation. Suspecting he finds it difficult to speak about suicidality in front of his father we interview Tom alone and after some enquiry he admits to

frequent suicidal thoughts like taking pills or jumping off a cliff, and then the bombshell. In the previous six months he has taken two serious Panadol overdoses, on both occasions seeing his GP for associated vomiting without disclosing the cause or informing his father, therapist or anyone else.

As Tom tells his story I wonder about his extreme level of secrecy about suicidal thoughts. Is there a general difficulty expressing feelings and how is this related to his family background? I recall his father seemed emotionally unexpressive and given Tom's disrupted relationship with his mother, begin to understand why he might keep his feelings to himself. I recall a similar shame about expressing feelings of despair and loneliness during adolescence and wonder if Tom is trapped within a self-constructed wall of silence feeling all the more desperate for it.

From this *psychodynamic* stance of the counter transference I take in and think Tom's emotional pain and his struggle with depression and secrecy. This reverie inspired me to talk in a *psychoeducational* way about the incidence of depression, suicidal thinking and self-harm in the adolescent population. I attempt to normalize his experience and reassure him suicidal thinking in young people is not uncommon and nothing to be ashamed about. In a *cognitive therapy* way I then explore and challenge Tom's beliefs and reasons for remaining secretive about his suicidality. Next from a *narrative therapy* perspective I refer to the importance of exposing suicidal thinking, explaining

like a virus *it* traps you into keeping its secret, which increases its power. I suggest the best disarming strategy is to confide in others and with my colleague stress the importance of doing this, *right now*, with his Dad in a *systemic family interview*, which explores their relational bonding. Here we explain an ethical obligation to inform parents about suicidal risk.

In my inner conversation as a therapist (Rober, 2005) I move freely between these therapeutic languages and forms of therapeutic knowing in response to the outer conversation with Tom, his father and my colleague. This integrative process brings together my training in psychoanalysis, cognitive and family therapy, clinical intuition and experience, responsibilities to implement protocol for managing suicidal risk, acquaintance with the evidence-based literature for adolescent depression, and so on (Larner, 2003). At the same time I work from a *not knowing* position in being curious, open, flexible and responsive in the therapeutic relationship. Taken together this double stance, which I have called *knowing not to know* involves an ethic of hospitality towards different languages of therapy (Larner, 2000).

In this way psychoeducation, psychodynamic, narrative, cognitive and systemic therapies contributed to an evidence-based management plan for Tom's depression and suicidality. All this occurred in the context of a risk assessment in a hospital emergency setting. Here my inner conversation about different therapy approaches was integrated with Tom's personal and family narrative; it became part of the *outer* conversation between Tom, his father and

my colleague and eventually the hospital staff, my team manager and the treating therapist. As a result Tom began to share his inner conversations about suicidal thoughts in dialogic connection with his father.

At follow up a week later Tom reported feeling less depressed and suicidal with his father making more effort with their relationship and communication. Tom opted to continue seeing his private therapist and declined medication. With Tom's permission the latter was given full details of his presentation. On two months review Tom reported the absence of depression or suicidal ideation and he was discharged.

Unfortunately four months later Tom was brought to hospital by the police under schedule following a recurrence of severe depression, deliberate self-harm involving cutting his arms with a razor, persistent suicidal ideation and a specific plan to hang himself. He was assessed as having major depression and a high risk of suicide, with the adolescent psychiatrist recommending psychotherapy and treatment by an SSRI. Tom had stopped seeing his therapist, so I arranged to see him for individual psychotherapy including monthly joint sessions with his father and he was reviewed by the adolescent psychiatrist every 2 months.

Over the next three months I used a cognitive therapy approach to help Tom integrate his thoughts and feelings about his depression in the context of a psychotherapy relationship. This utilized writing tasks to facilitate Tom's narrative voice and addressed attachment issues and trauma associated with the

relationship breakdown with his mother. As well joint sessions with Tom and his father focused on psychoeducation, communication, ways to build their relationship, as well as building a safety net in relation to Tom's suicidal risk. Family therapy also negotiated autonomy in the father-son relationship, as Tom complained his father was unduly restricting his peer relationships by imposing unreasonable curfews. Individual therapy also explored the adolescent culture for expressing emotions in contemporary society.

There was significant improvement in Tom's depressive condition, as he said: "I can tell Dad when I'm not feeling too good and he understands. I feel I can be more open. If he knows what's going on he'll be more understanding rather than if it all comes out at once". This was good news particularly given Tom's sleeper history of impulsive suicidal behavior. However four months later there was another relapse, although this time Tom was able to tell his father and myself about his deteriorating condition. He had developed a major sleeping disorder, which exacerbated his depression and was experiencing anxiety in relation to his final school year exams. I contacted the school to see if they could help to reduce his academic stress.

I continued to see Tom for individual and family therapy and three months later he was sleeping better, his depression and suicidality had resolved and he was hopeful about finishing school and attending university. Tom accounted for his progress as follows: "The medication helps, but the main

thing is changes I've made in my way of thinking. If something little goes wrong I don't let it affect me as much".

Conclusion

The current evidence-based literature supports an integrative approach to therapy with depressed adolescents, their families and the various professional and therapeutic systems involved with their care. This combines an individual psychological treatment like cognitive therapy with pharmacotherapy where required and a family therapy approach that addresses psychoeducation, parent-adolescent relational conflict and attachment issues.

The paper has described a systemic framework for integrating family therapy in the evidence-based treatment of adolescent depression based on an ethical stance. Here integration is defined as a systemic capacity to think and converse in *many* therapeutic languages at once. In working with adolescent depression or any other psychological issue, this brings together different therapeutic models and frameworks, wider helping systems and the narratives of young persons and their families into dialogue and conversation.

In the current politics of evidence-based practice it is important for family therapy to form integrative links with other disciplines (Larner, 2004a). This provides opportunities to reconfigure systemic theory and practice as described in this paper. An ethical stance for working and speaking across diverse theory, language and therapeutic communities allows family therapists to integrate evidence-based treatments for adolescent depression.

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Chapter 10 Summary and Reflections

In part this thesis has addressed a compelling and inescapable theory and practice issue, one which has increasingly confronted family therapists over the last decade and is likely to continue to do so well into the next, namely: how to be a systemic, dialogic or narrative therapist in a modern scientific and evidence-based world of therapy. This is a dilemma not just for relational therapists like the author who are employed within mainstream therapeutic professions such as psychiatry and clinical psychology, but for family therapy in general. As Gouze and Wendel (2008) note the field is now at a crossroads, which is defined by the following integrative task: “how to incorporate the wisdom of previous models with the accountability that comes from evidence-based practice” (p.269). This is a significant challenge as family therapy evolves a more elaborate systemic and dialogic framework (Bertrando, 2007; Flaskas, 2005; Rober, 2005; Wilson, 2007) *while* taking on board recent evidence-based and integrative developments within the discipline (Carr, 2009a, 2009b).

To this end the thesis has proposed deconstructing therapy in the ethical relation as a possible way forward. Radically unlike a postmodern or social constructionist stance in therapy (e.g. Anderson, 1997, 2009), this does not require relational therapists to abandon and move beyond a modern science or

technology of therapy, but rather to engage with it, asking: how can I utilize a diversity of therapeutic paradigms, knowledge and techniques in a way that puts the relation to the other first and alleviates their suffering? This ethical imperative cannot be more plainly expressed than by Levinas (1993) in the following statement: “Science and the possibilities of technology are the first conditions for the factual implementation of the respect for the rights of man” (p.119). Following Levinas (1998) modern knowledge is not rejected but grounded in the ethical relation to the other as “a different form of intelligibility and...loving wisdom” (p.vii).

As the thesis has argued such an *ethics-first* philosophy allows family therapists to apply a range of therapeutic languages from a deconstructive or *paramodern* stance. Modern structural, strategic and family systems approaches can be integrated with postmodern innovations in systemic and dialogical thinking, while utilizing evidence-based approaches from within and without the discipline. As Wilson (2007) notes, in the evolving theory and practice of family therapy: “Ideas interweave; they roll back on one another” with “greater openness in exchange between theoretical models” and “less defensiveness between previously opposing schools” (pp.14-15). Or as Rober and Seltzer (2010) say, the challenge for family therapists is to avoid rigid ‘colonizer positions’ based on prevailing ideologies, so as to remain vulnerable and open

to the family's suffering and experience in the interactive dialogue of the therapeutic relationship.

These sentiments mirror the description of the ethical relation in this thesis. The ethical is to be moved at a fundamental level by what it means to be a human being; it is a pre-conscious experience of relationship and encounter with another person. To be open to the therapeutic encounter is an experience of the other person that carries a sense of strangeness, mysteriousness and wonder. However this doesn't detract from but rather enhances my responsibility as a therapist to respond to their psychological and relational suffering in the most effective and scientific way possible. The ethical priority is to utilize whatever approaches and technologies are effective in systemic work with individuals and families. As a therapist this challenges rather than eradicates my knowing and expertise and is an invitation to responsibility, to use whatever means, knowledge or technologies are at my disposal to assist another person.

As outlined in the thesis, for family therapists this can include useful ideas and practices from other disciplines, like neuroscience, psychiatry, cognitive therapy or mindfulness-based psychology as required, especially when dealing with complex presentations like adolescent depression. An integrative practice model is consistent with a systemic spirit of enquiry in family therapy; it facilitates dialogue across different therapeutic paradigms as an *ethic of hospitality*. In this discursive process family therapists can

participate in open dialogue with non-systemic colleagues and the modern therapy profession in general, about what systemic and dialogic approaches have to offer. Such interplay between different therapeutic paradigms heralds exciting and creative possibilities for the future of family therapy. As mentioned above and throughout the thesis, there are increasing illustrations of this ethical and integrative process in the recent therapy literature. Another interesting example is Sundet's (2010) application of the language based philosophy of Vygotsky and Bakhtin to develop evidence-based conversational tools for monitoring process and outcome in a hospital-based family therapy unit.

In summary the thesis has described different aspects of deconstructing therapy in the ethical relation. First Chapter 1 presented a detailed synopsis of 12 key previous publications by the author, which established a broad theoretical framework of deconstructing therapy. This provided a platform for exploring the ethical relation in therapy. Following Derrida, Chapters 2 and 3 established that deconstruction *is* ethical and argued the priority of speaking the language of the other in psychology and therapy. This integrates a range of therapeutic languages and approaches as an ethic of hospitality. Chapter 4 then proposed *ethical irreverence* as a guiding metaphor for contemporary family therapy. This linked the systemic idea of *irreverence* in family therapy to the wider philosophical landscape of Derrida's deconstruction as an ethical gesture.

From there chapters 5-7 expounded the philosophy of Levinas to develop the main theme of the ethical relation in therapy. First Chapter 5 articulated a discourse ethics to propose an ethical ground for relational and dialogic therapy. This suggested whatever theory, language or model of therapy is applied first belongs to and is spoken *for* the other. Chapter 6 then presented the idea that therapy constructs an *ethical container* for thinking and relational meaning to grow as a *knowing not to know*. This brought together the thought of Levinas and Bion to map further intersections between psychoanalysis and family therapy.

Next Chapter 7 theorized the systemic, reflective and dialogic self of family therapy as ethical relation. Following Levinas, while the ethical defines the self or subjectivity, to be responsible for the other requires a strong sense of a coherent, integrated and independent individual capable of agency and intervention. The ethical self is deconstructed or needs to be seen from both a modern *and* postmodern perspective. That is, while the self is contextual or socially constructed through dialogue, it also has a stable and integrated sense of identity or ‘narrative of destiny’. Radically this allows a version of the modern self theorized by disciplines like biological psychiatry, cognitive psychology and neuroscience to be thought within a relational and dialogic framework for family therapy.

Finally chapters 8 and 9 demonstrated an integrative model for *ethical practice* in family therapy, which was illustrated by clinical examples of child chronic medical illness and adolescent depression. In the ethical relation modern and postmodern paradigms are integrated to define a systemic, relational or dialogic science of family therapy. This is scientific or evidence-informed *and* grounded in the interaction and dialogue of the therapeutic relationship at the same time. It was suggested such an ethical integrative model reflects state of the art research into effective therapy for complex mental health presentations like adolescent depression. This integrates modern languages of risk assessment, crisis intervention and evidence-based psychiatry and psychology, while working systemically with personal and family narratives from a family therapy perspective.

In conclusion this thesis is very much a dialogue in process; it is not a final product but the beginning of an enquiry. It is an evolving dialogue with my clients in teaching me what it is to be an ethical therapist. A dialogue with a community of practitioners and scholars in family therapy and in social constructionist and critical psychology. With my colleagues in clinical psychology and in child and adolescent mental health services in developing a viable integrative and ethical philosophy of practice. With the readers of the publications that form the thesis and a range of audiences at presentations, workshops and conferences. Also with my supervisor and now you the reader of

the thesis. In many ways the work of the thesis as deconstructing therapy in the ethical relation is only just beginning.

What more can be said? I leave the final word to Derrida (1999) from a book commemorating the life and work of his friend and colleague Emmanuel Levinas: “There can be no acontextual definition of a human being” (p.83).

Now that is a deconstructive message well worth broadcasting to the wider field of therapy from a stance of hospitality and engagement in the ethical relation, as this thesis has attempted to do.

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