

# The complexity of listening in family therapy practice

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## **Abstract**

In this paper I emphasize that listening in family therapy practice is complex and by no means obvious. I referred to three ways of listening; with the ears, the eyes and the heart. With his/her ears the therapist listens to the story told by the client. With his/her eyes the therapist can see what it emotionally means for them and he/she can observe the response of the other family members (e.g. their hesitations, ...). Then there is the listening with the heart. The therapist is spontaneously responsive to what happens in the session and while he/she is responsive he/she can notice and be surprised by what is evoked in him/her.

This view on the complexity of listening is illustrated by means of case examples, most notable the case of Mick and his dinosaurs.

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### **Case Mick and his dinosaurs**

*The Cox family was referred to me by a policeman of the program "Bereavement by Suicide" of the local police. Father had committed suicide a year ago. Mother and the two children (Mick aged 9 and Amelie aged 12) had followed the program offered by the police service. Now, one year after the suicide, the family was referred for family therapy.*

*When I went to pick them up in the waiting room, I saw them sitting in silence.*

*Mother was lost in thought. Amelie was browsing in a magazine. Mick was playing in silence with two latex toy dinosaurs he had brought with him.*

*I shook hands with mom and I introduced myself. Then I shook Amelie's hand and when I wanted to shake Mick's hand, he did not offer me a hand to shake. Rather, he kept his two menacing dinosaurs facing me. "Grrr," he said.*

### **The family members tell their stories**

In the past 20 years, the narrative turn in psychology, philosophy and the social sciences had a significant impact on the family therapy field. Narrative therapy has become very important (White, 1991, 2007) and an increasing number of family therapists now use narrative metaphors to talk about therapy. They suggest that clients in the session tell stories about their lives and their families.

No doubt the story perspective has enriched the family therapy field. It helped family therapists to better understand how people make sense of their experiences and give meaning to their lives. McAdams (1997), for example, connects identity with stories, when he writes that people are the stories they tell about themselves. A person's identity will take the form of an inner story, complete with scenes, characters, plot and themes; giving life a sense and some coherence (McAdams & Janis, 2004). These narrative ideas are important for our field because they inspire family therapists to find new and richer ways to understand the suffering in families (White & Epston, 1990; White, 2007). Furthermore, by the introduction of narrative thinking in the field, family therapists have chosen to take a fundamental ethical position: a therapeutic relationship as primarily a relationship of collaboration or co-

authoring (Anderson & Goolishian, 1988; White, 1991). The task of the therapist is described as listening to tell the stories of their clients, and making room for the stories that have not been told before (Anderson & Goolishian, 1988).

In the beginning of the new century, a new perspective began to emerge in the field of family therapy. This perspective puts the spotlight, not on the stories themselves, but on the telling of the stories (e.g. Rober, Van Eesbeek & Elliott, 2006. Wortham, 2001). While stories reflect who is the narrator, in telling the story the relationship between the narrator and the listener is central. Storytelling is an action in context, as storytelling occurs in the presence of others who listen to the stories. Referring to some of Bakhtin's ideas (Bakhtin, 1981, 1984, 1986), we can conceptualize storytelling as a dialogical phenomenon: stories are told using dialogical instruments such as words, expressions and genres. The relationship is central: the story I tell is not my story; it is our story.

### **The other**

Storytelling is inconceivable without the other; without someone who listens. Storytelling is telling somebody about something, but in the first place it is about recognizing oneself and each other. I am myself but through you. This is the main idea of the philosophy of dialogue, and a lot of philosophers have highlighted the primacy of the relationship, over the individual (e.g. Buber, 1923, 1947; Levinas, 1969; Derrida, 1978).

In the family therapy field the dialogical approach has been mainly inspired by Mikhail Bakhtin (1981, 1984, 1986). Based on his ideas, we can describe a family therapy session as a forum in which stories gradually, in unpredictable and in unique ways, develop out of the tense interaction of all interlocutors. Each expression is responded to in some way: implicitly or explicitly. It is listened to and evaluated by the others, and their verbal and nonverbal responses invite new expressions in a complex dialectical dance of differences and similarities (Baxter, 2004).

Listeners are co-authors of the story. In the seemingly natural and automatic flow of the dialogue, the family members and the therapist together tell the story of the family; the speaker brings his/her experience into words and listeners (other family members and therapist) contribute to the story that develops through the questions they ask, through the interest they show, through the way they bodily are present, etc. In that way, the story is an interactional achievement that *emerges* between people, with each participant contributing to the telling, immersed as they are in the flow of their *we*.

### What is said and what is not said

While family therapy is focused on the sharing of stories, in family sessions there are also stories that are not told. Rogers, Casey, Ekert, Holland, et.al. (1999) recognize a range of unspoken stories: "From the unsaid (what is simply not said or missing), to the unsayable (what is difficult to say but may be implied through negation, revision, evasion, or silence), to the unspeakable (what points to a knowledge that is dangerous or taboo)." (p.91-92).

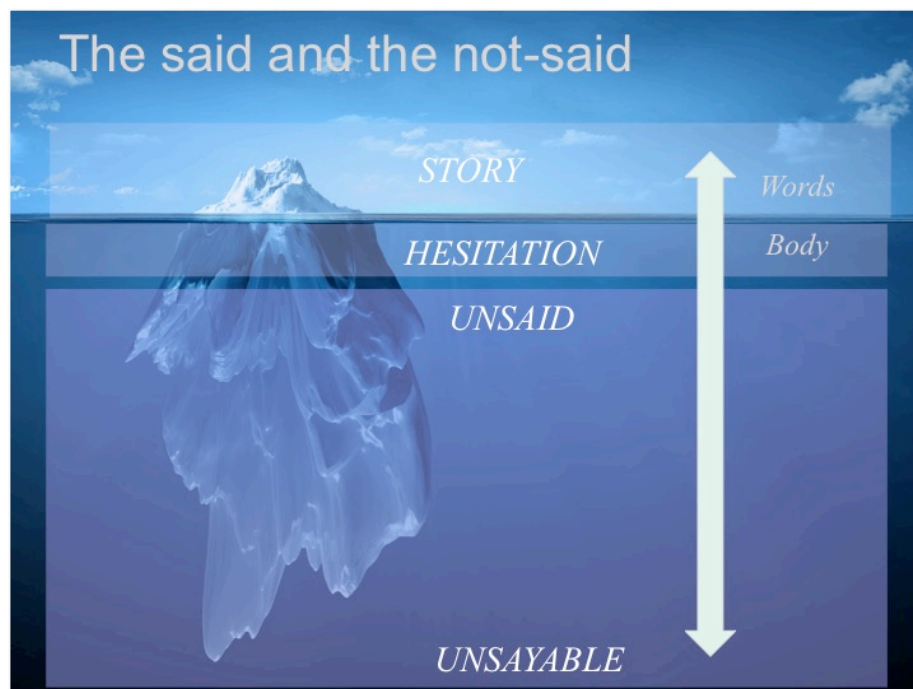


What is actually said in a conversation is the result of a moment-to-moment implicit process of selection in which the quality of the dialogical context is central. The context may be safe to tell new things, or it may be unsafe so the speaker will only

tell stories that he/she has told a hundred times before. In therapy for instance, the therapist wants the context to be safe enough to improvise (Byng-Hall, 1995) in such a way that stories that have not been told before (unsaid) are evoked in the client. In such a context the client is invited to search for the right words to express what has not been expressed before.

### **Hesitations and their non-verbal expression**

The relationship between the said and the not-yet-said is not a simple one. Instead, it is a complex, dynamic relationship where what is said can only be understood in the context of what is not said (Rogers, et.al. 1999), and where what is said reveals and conceals at the same time (Lakoff & Johnson, 1980; Billig, 1997). Between the concealing and the revealing there is the hesitation (Rober, 2002). Very often storytelling is preceded by a moment of hesitation. Such an hesitation can be understood as a compromise between two movements, the movement toward speaking, and the movement that holds back the words. The compromise is often expressed in a nonverbal way (e.g. a pause, a sigh, ...). The body speaks when the words don't come.



### **The therapist listens**

A family therapist must listen carefully to the stories the family members tell. The aim of this listening is not in the first place to gather information in order to make hypotheses or to formulate a diagnosis. Rather, the central aim of listening is to connect with the family members in such a way that they feel heard and that they experience that they are acknowledged by the therapist in what they are going through, and in their good intentions. Put in this way, listening is a fundamentally ethical activity within the therapeutic relationship as an *I-Thou* relationship (Buber, 1923, 1947).

### **Listening is not obvious**

By no means, listening is obvious. It is active as it implies being not-knowing (Anderson & Goolishian, 1988) and curious (Cecchin, 1987) in order to receive the story as the client tells it. It implies listening to the broad strokes of the story, as well as to the details.

The therapist listens to the story of the clients; the plot; the main characters, the events, and so on. But while the therapist is listening to the story, he/she also notices the small details in the story itself, as well as in the way it is told. The small details often give some indications of what can't be said (yet) for whatever reason. It is often a small detail, something very easily overlooked, but the therapist notices it and recognizes it as important. Still, it does not lead to hypotheses or to judgments; rather it sparks reflections about possibilities and potentialities. It awakens the curiosity and interest of the therapist, and gives rise to respectful questions posed to the client such as 'can I tell a bit more about it?' or "can you help me understand?"

When a client tells a story, the therapist listens carefully to what is said. The therapist's listening means a lot to the client, especially when the client tells about experiences that are personal and vulnerable. This listening to the story of the client could be called, *vertical listening*. In a family therapy session, vertical listening, while

important, is not enough. The therapist also has to pay attention to the responses of the other family members to what is being said. This could be called, *horizontal listening*. Both kinds of listening, vertical and horizontal, are indispensable in a family therapist's listening.

Both vertical and horizontal listening has to be done with all the therapist's senses; The therapist listens not only with the ears but also the eyes and the heart. Let's look closer at what this means.

### **To Listen with the ears**

The therapist listens to the story as told by the family members and tries to understand the story as well as possible. This sounds obvious, but it is not. Understanding is not in the first place something in the head of the therapist; rather understanding primarily happens bodily, between therapist and client. The body understands before the brain has processed the information.

Listening with the ears is only in part passive, as it is complex and also implies hard mental work. It implies listening to what is said, as well as listening to what is not said. In the family therapy context, it implies listening to the speakers, as well as to the listeners. To listen with the ears is in tension with categorizing and labelling. The focus is on the unique story of the client, not on the story that puts the client in the same box as a typical group of clients. This means that in order to listen, the therapist has to avoid or at least to postpone judgment and diagnosis. This is not evident in these times in which psychotherapy is often described as a medical practice in which the diagnosis is the starting point of the treatment. In our dialogical view of family therapy, the diagnosis is important only if it features in the story of the family members.

Rather than diagnosing family members, the therapist listens to their stories and tries to hear their stories as humane stories about something that he/she also might have experienced, if the circumstances in his/her life were different. The therapist

listens to what the family members tell him/her, and this listening is connecting them as limited mortals with good intentions: a bridge between them develops.

The therapist listens generously. Listening generously is the opposite of listening critically. It refers to the listener assuming that the speaker intended the most coherent and reasonable meaning imaginable (Hoffman, 2002; Shawver, 2004; 2012). It means to listen to the other as if he/she is *me*, and to refrain from judging or diagnosing.

Here lies one of the main reasons why family therapists have to be careful with diagnostic labels. Such labels do not convey empathy, as they imply a judgement; the judgement that the behaviour is not normal. A diagnostic label used by the therapist also suggests that the therapist considers him/herself different than the client (more normal, more healthy, more sane, ...), and in fact it also suggests a distinction from the other family members (who are also more normal, more healthy, more sane, ...). Saying to someone (or even just *thinking* about someone) "*You are autistic*" implies that one considers the other as different: "*You are autistic, and I am not.*"

In listening the therapist identifies with the client as a person, and allows him/herself to see a reflection of his/her own suffering in the suffering of the client. It's that reflection that can help the therapist to create a bridge to the other, "Although I am not autistic, sometimes I also need to close myself off from the world..." or "Although I am not autistic, sometimes the world is very strange to me ...", etc. It is in the humble recognition of the humane in the strangeness of the other, and in the recognition of the strangeness in him/herself that the therapist recognizes the client as a *Thou*, and him/herself as a subject (Buber, 1923).

Often it is best to respond to what we heard with our ears by asking questions like "can you tell me more?" and "can you help me to understand?" In that way, we convey our interest in the stories that are emerging, our curiousness about the life experiences of the speaker, as well as our not-knowing openness. Such listening is



particularly powerful in family therapy. If the therapist listens to the story of one of the family members without judgement, but rather with the recognition of understanding and empathy, the other family members present are humbled and at the same time reassured that when they tell their story, they will be listened too in the same generous way.

### **To listen with the eyes**

Listening with the eyes refers to the non-verbal communication of the family members. The family members tell their stories not only with words but also with their body: facial expression, body movements, breathing, tears, etc. Words often can only partly grasp what the body can express.

Furthermore, family members respond to the stories told in the session with their body first. They sigh, or they look away, or they start to cry. That's why it is important that the therapist integrates his/her listening with the ears with his/her listening with the eyes. For instance, it is important to note that the client's eyes become watery, and the therapist can try to understand what that might mean: *Who was speaking at that moment? What was said at that moment?* And so on.

### **Case Story: The Smedts family**

*I had a conversation with parents who lost their child. The father sat in silence as the mother told about the long nights sitting at the hospital bed with their daughter.*

*Mothers story sounded dull. Without much emotion.*

*Still, I knew there had to be a lot of emotion. Somewhere.*

*I asked:*

*"What is the last thing your daughter said?"*

*Immediately mothers were full of eyes. My question catapulted her back to a specific moment in the months long process of her daughter's illness. She was back at the hospital with her sick child. She remembered that her daughter had said to her: 'Do not worry, Mom, it'll be fine.'*

*However, in the session with me, the mother could not say this. She had no words, but I saw her shoulders shake, and she leaned forward and grabbed her arms around her stomach, as if she had severe abdominal pains. Tears were dripping on the floor.*

*The father moved closer and without words he took her in his arms and comforted her.*

*I got tears in my eyes and took a handkerchief to dry my eyes.*

This is an example of the body that speaks; or rather of bodies that speak. For it is not only the mother's body, but also the body of the father, and even the body of the therapist that spoke.

### **To listen with the heart**

This is perhaps the most difficult kind of listening.

It has two aspects:

1. Being in the moment with the family members, and responding intuitively in the flow of interaction.
2. Reflecting on what is evoked in the therapist (e.g. emotions, ideas, memories, ...)

This idea of listening with the heart connects with the idea that the therapist's actions are relational responses that are intuitively and bodily in the first place. First there is the other, and immediately our body has a response. And then, as if it were as an epiphenomena, there is our thinking, our reflections, our hypotheses, ... (our cognitions) These cognitive activities are in constant dialogical tension with our bodily responses; reinforcing them, correcting them, inhibiting them, ... The interaction between the bodily immediate responsiveness and the cognitive reflections can be seen as a dual process:

- *Process 1:* without much explicit reflection, as it were from a default position (Reimers, 2006), the therapist acts in the flow of the dialogue, immersed in a shared *we* with the family, intuitively searching for some kind of attunement. This process is also referred to as "fast thinking" (Kahneman, 2011).

- *Process 2*: the therapist is goal oriented and observes what happens, processes information, evaluates the evolution, and so on. This process is also referred to as “slow thinking” (Kahneman, 2011).

Cognitive dual process theories can capture the complexity of this process: the theory of Daniel Kahneman (2011) for instance or the theory of Donald Schön (1983). Process 1 is captured by Schön’s concept “knowing in action”, and process 2 by the concept “reflection in action”. It is optimal if the therapist can flexibly move from intuitive responsiveness to cognitive reflection and back again, and if, attuned to the family’s rhythm, a balance is found between the intuitive actions of the therapist immersed in the flow of conversation, and his/her perceptions of what is happening in the session enriched with his/her self-awareness of his/her inner dialogue.

While Kahneman’s process 1 refers to the therapist who is responsive in the present moment, his process 2 refers to moments of reflection. The therapist as is were stops the time and takes some mental distance to reflect on the process and on his/her involvement in the process. Such reflections are often about the feelings and experiences evoked in therapists by the family. Sometimes strong emotions are evoked in him/her (e.g. Frediani & Rober, 2016). Pope & Tabachnick (1993) asked 600 randomly selected professional therapists in a survey study about the feelings they have experienced in their work. Over 80% of the respondents reported experiencing fear, anger, and sexual feelings in the context of their work. The most widespread feelings were fear and anger, both experienced by 90% of the respondents. This research illustrates that experiencing negative emotions is an inescapable part of the messy and unpredictable process of therapy and should not be considered as a sign of being a bad or inexperienced therapist.

Some authors have emphasized that the personal experience of therapist is a source for creative interventions (e.g. Andolfi, Angelo & The Nichilo, 1989; Whitaker & Keith, 1981; Wilson, 2007). Especially in working with children, but also in working with adults, play, humour and drama are important aspects of the therapeutic

dialogue. Also the sharing with the client of therapist's own associations, fantasies, and bodily sensations is not uncommon for these therapists (eg. Whitaker, 1989). Furthermore, the therapist's own experiences can be helpful in ensuring that the therapeutic relationship is a warm personal working relationship that is experienced by the client as authentic and empathetic. If the therapist actively wants to contribute to an effective therapeutic relationship, rather than playing the "role" of therapist, then he/she should really be present in the session as a person.

Of course, the therapist has to avoid giving in to the temptations of hubris and colonisation (Rober & Seltzer, 2010). This implies being *not-knowing* (Anderson & Goolishian, 1988) and bracketing one's prejudices and theoretical preconceptions in order to be open for the story the client wants to tell. Furthermore it implies that the therapist should be aware of his/her phantasies of being a benevolent healer, in order to make space for a real dialogue with the clients in which there is room for the clients' discomfort with the therapy and his/her criticism of the therapist, without the need to break the connection or to stop therapy prematurely.

According to some authors what the therapist experiences during the session is particularly meaningful as it sometimes tells part of the client's story: our clients make us feel what it is like to be them.

What the therapist experiences reflects some of the things the client cannot express in a verbal or a non-verbal way. Psychoanalytic inspired family therapists argue that this form of communication functions through the mechanism of projective identification (e.g. Flaskas, 2002) and is expressed in what they call the *countertransference*. Elkaïm (1997) situated this form of preverbal communication in a systemic frame. He stated that the personal experiences of the therapist in the session can be seen as a therapeutic tool that provides information about the system. According to him, what the therapist experiences in the session is not only the result of the therapist's own personal history, but it is also evoked and reinforced by the dialogical context in which the therapist is invited to play a part (Elkaïm, 1997).

So it seems that we have to listen to our own experiencing process in order to better understand the stories of the family members (Rober, 2011). However, being sensitive to one's own experiencing is no simple matter. The therapist has to be aware of his/her own experiences, to bear them and to tolerate them; instead of acting impulsively on his/her emotion (Rober, 2011).

Being aware of one's experiences in the heat of a family therapy session is usually tough. According to Frosh (2004) dealing with the unsaid and the unsayable may be frightening for therapists as clients appear as *Others* (Larner, 2004) or as *strangers* (Kristeva, 1991), while at the same time they demand something from the therapist: "When clients say, 'help me, cure me, reach me,' what on earth do they want? And why, especially, do they want it from me?" (Frosh, 2004, p.60) The client's suffering and his/her expectations can evoke feelings of impotence and helplessness in the therapist. It may also stir up the issue of feeling like an impostor (Clance & Imes, 1978; Sigtler, & Wilson, 2001), as it can give rise to the therapist's secret fear that he/she is not worthy of his/her position as a therapist.

Impulsively acting can be our way of protecting ourselves: triggered by the client's suffering we intervene and in that way we keep strangeness at bay and avoid to really be aware of some of the confusing and painful things that are evoked in us. That's why carefully reflecting on one's own experiencing and positioning in the session is important. It is however not always possible to find the time and space to really reflect on these things in the session. Taking time after the session to think over what happened, or even better, to talk with colleagues or with a supervisor about the session, is no luxury, but rather a necessity. It is important for the therapist to find ways in which his/her experiencing can open space for new and enriching dialogues with the family members, between the family members, and between family members and their social context.

#### **Case Mick and his dinosaurs (continued)**

...

*Mick kept his two menacing dinosaurs facing me.*

*- "Grrr," he said.*

*- "Wow, they look dangerous," I said, "I'd better be careful, shouldn't I?"*

*- "Grrr."*

*It sounded stronger. More threatening. He had gained confidence.*

*- "Good thing you brought your two friends. They can protect you so that nothing bad happens to you three," I said.*

*- "Grrr."*

*- "Be polite and shake the therapist's hand, Mick," Mother said.*

*Mick took both dinosaurs in his left hand and reached out with his other hand to me.*

*- "Hello Mick," I said, shaking his hand.*

*We went into the consultation room.*

When I meet a family in the waiting room before a first session, I just follow the social rules: introducing myself, smiling politely and shaking hands with every family member, inviting them to connect with me and start a relationship of collaboration. Doing this, I am curious to see (and experience) how they deal with my invitation. Do they accept my invitation or not? How do they accept it, or reject it? I also know that often the family members who are most hesitant to start the process are most likely to reject my invitation (Rober, 2002). Often they will let me experience that they are reluctant to accept my invitation. In that sense, already in the waiting room I expect to immediately be confronted (often in a subtle way) with some of the unique stories of the family. Very often there is something that stands out, something that surprises, something that happens at the moment, and may never happen again in exactly the same way. In the case of the Cox family, for example, the way in which Mick presented himself was special: he initially refused the hand I offered, and he showed me his two menacing dinosaurs. I realised that this was an important moment. While he rejected my invitation, he immediately presented me with his own invitation. He invited me connect with him by doing something that fell outside of the usual known social scenarios. This moment, I felt, was an invitation to meet each other in a spontaneous, playful way. As a therapist, I could have chosen to remain at a distance and make a mental note of what I observed as it

could turn out to be a crucial observation for developing a hypothesis. This may have felt more professional and more safe. However, I seized the opportunity to take a chance to meet the boy in his world, as he presented it to me.

So when Mick stretched out his little arms with the toy dinosaurs directed to me, without much reflection I dove right into his world. The dinosaurs were at that time no plastic toys anymore, but real menacing beasts: *"Wow, they look dangerous. I'd better be careful, shouldn't I?"* There was no reflection before I said these words. This is the process Kahneman (2011) wrote about (see above). The words came naturally out of my mouth, and I only realised what I said at the moment that I heard my own words. However, these words are not just random; implicitly there was knowledge in my action (Schön, 1983). There is a kind of implicit rationale for these words that in retrospect I can unravel and explain. The words were my playful way of being responsive to the way Mick presented himself to me. Rather than declining his invitation to meet him in a playful as-if world of menacing dinosaurs, I choose to accept it and I agreed to bear the discomfort of taking this risk of venturing into unknown territory. I did not only accept his proposal to consider his toys as dangerous dinosaurs and but I immediately suggested to Mick also that I took them seriously by proposing a particular relational significance for the animals: I suggested to Mick that the dinosaurs were there to protect him and his family, and that I as a therapist had better be cautious, or otherwise they would get me. My response was consistent with the idea that at the outset of a family therapeutic process the family is anxious and insecure, as they don't know what will happen during the first meeting. It could be said that in my response to Mick's dinosaurs implicitly a kind of listening was included, but I choose not to make it explicit, as it would position me again at a professional distance from him. No, at the moment of encounter with Mick I choose to be close to Mick; as close as was comfortable for him. Without much reflection I connected with him, and I postponed taking a more reflective position of hypothesizing about Mick and the family's functioning to a later moment.

In retrospect, I can make explicit that my verbal response *"Good thing you brought your two friends. They can protect you so that nothing bad happens to you three,"* in

fact shows that I listened to the untold story that was expressed in his threatening movement with the dinosaurs. Indeed, in the later session they told me that a year ago when their father shot himself in the head, he was not killed instantly. Rather he remained in a coma for a week. He was nursed in a hospital, and then he died. For Mick going to a family therapist whose office is in a hospital raised his sadness, his anger and also his fear of hospitals. The dinosaurs were given to him by his teacher Ben, who –after talking to Mick’s mother, gave Mick some extra attention and sometimes talked to him in private in order to support Mick in the difficult period after his father died. Interestingly, Ben had given the dinosaurs as a present to Mick and had told him that these are “mean animals that can protect you when you feel threatened and afraid”. I learned these things only later in the first session, but it seems that in the waiting room I have listened to the introduction of his dinosaurs in such a way that implicitly I had understood in some way at least part of his untold story.

### **Towards a conclusion**

In this paper I emphasized that listening in family therapy practice is complex and by no means obvious. I referred to three ways of listening; with the ears, the eyes and the heart. This view can be summarized in the following figure:





With our ears we listen to the story told by the client. With our eyes we can see what it emotionally means for them and we can observe the response of the other family members (e.g. their hesitations, ...). Then there is the listening with the heart. We are spontaneously responsive to what happens in the session and while we are responsive we can notice and be surprised by what is evoked in us. When we are aware of our own experiences in the session, sometimes it can give hints of the client's experiences that has remained unsaid and sometimes even unthought.

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