This is the published version:

Furlong, Mark 2008, Captured by the game: might a focus on the ‘therapeutic relationship’ diminish the attention we give to the client’s intimate network?, *Australian and New Zealand journal of family therapy*, vol. 29, no. 1, pp. 25-33.

Available from Deakin Research Online:

http://hdl.handle.net/10536/DRO/DU:30042521

Reproduced with the kind permission of the copyright owner.

Copyright: 2008, Cambridge University Press
Captured by the Game: Might a Focus on the ‘Therapeutic Relationship’ Diminish the Attention We Give to the Client’s Intimate Network?

Mark Furlong

Keywords: therapeutic relationship, social network

A recent project sought to clarify how psychotherapists and mental health workers understand psychosocial health and pathology. In this enquiry, I paid particular attention to the client’s interpersonal networks: did the professionals actively consider, and if so to what extent, ‘intimate social and family relationships’ in constructing their understanding of the presenting problem and in the process they used for goal setting. Twenty-two semi-structured interviews were undertaken, eleven with psychotherapists and eleven with mental health workers. Across both groups, interviewees tended not to see their clients as embedded, relational entities, but primarily, often quite exclusively, as autonomous beings. Second, interviewees accorded a high value to the importance of ‘the therapeutic relationship’. Is it possible that the emphasis practitioners place on ‘the therapeutic relationship’ has the effect of marginalising the attention that is given to the client’s significant-other network?

Contextually-oriented therapists have long been interested in social networks as well as families. Such networks are now recognised as having an important influence on the psychosocial health of ‘ordinary’ citizens (Berkman & Glass, 2000; Bunker et al., 2003; Ryff & Singer, 2001). They are also important for securing positive, sustainable outcomes for those established clients of private practitioners and public agencies, for example in aged care (Lubben & Gironda, 2004) or mental health (Pinto, 2006). Of particular interest are informal networks, those social linkages that are less patterned than families and formal networks, as they can have a special unpredictability and potency.

For example, an individual’s most frequent, perhaps even most valued, contact might be with a neighbour rather than with a family member. Similarly, a now-deceased ‘aunt’, someone who was never technically an aunt at all, can remain the person with whom you still experience a nurturing bond, despite your ongoing participation in conventional kinships. Perhaps an individual’s firmest support, conceivably even his or her sense of life purpose, is taken from association with a group, like a trade union or a prayer group.

Yet, if I am a systemic practitioner, it is not clear which of my client’s ‘significant-other relationships’ warrants attention and how do I ration and prioritise this attention? In contrast to embracing this potentially fruitful sort of question, the majority of practitioners simply ‘work with individuals’. This seems the natural thing to do because in western culture, if not all others, it simply makes sense that ‘the individual’ should be the immediate centre of attention.

By contrast, when the boundary between the individual and their environment is not taken as the primary distinction, a set of more abstract categories have to be considered — such as ‘the social’, ‘the relational’ and ‘the contextual’. Engaging with these categories is like trying to get to grips with a set of Russian dolls. This discomfort reflects a certain cultural bias which the Franco-Indian anthropologist Louis Dumont summed-up with precision: ‘Western ideology grants real existence only to individuals and not to relations, to elements and not to sets of elements’ (Dumont, 1986: 9). So, given this messiness, given that ‘family’ and ‘network’ do tend to interpenetrate (Bott, 1968; Rapaport & Overing, 2000), how do practitioners actually think about their

Mark Furlong, Senior Lecturer, School of Social Work and Social Policy, Faculty of Health Sciences, La Trobe University, Bundoora, Victoria, Australia, 3083. Please contact Mark for a copy of the Interview Schedule, including vignette and questions. An earlier version of this paper was presented as a plenary address at the annual Family Therapy Conference in Hobart, September 2007.
The aim of the project was to clarify how professionals who ‘belonged’ to two different sectors of practice understood the importance, or otherwise, of their client’s connectedness to ‘family and friends’ in their construction of health and well-being, pathology and dysfunction. In this respect, the project clearly intersected with received family therapy theory in that the focus was on family and network. That noted, it was only after the data had been collected and analysed that I became aware that the results might be relevant to readers of this journal, practitioners who have a commitment to thinking and working with a family, systems and contextual orientation. I say this as the results of the study reveal something of the operations of ideology and culture, operations that are conducted within the subjectivity of clients, as they are in the practices of all professionals irrespective of our espoused theory.

The Project

This report is based on a larger PhD project (‘Disturbing the dream of the autonomous subject’) where the key research question was:

…to what extent, and in what manner (if at all), are affectionate relationships deemed to be relevant with respect to the matter of how practitioners understood ‘the self’, and with how these practitioners construct health and pathology, well-being and dysfunction?

Stimulated by this overarching question, I composed a number of more focused questions. These included the following: how do practitioners consider their clients’ affectionate and intimate relationships? More particularly, how do practitioners factor these past, present and future connections into their work? To what extent are these connections central to the practitioner’s formulation of the clients’ presenting problem, the clients’ longer term well-being and the actual goals towards which the practitioner strives? That is, what stance do practitioners take with respect to interpersonal relationships in their thinking about their clinical practice?

An introductory and exploratory exercise towards investigating these questions comprised gathering data from 22 semi-structured, face-to-face interviews with practitioners in two cohorts, as described above. (Further detail about the project is available from the author.) The interview schedule allowed for open-ended as well as specific-response data. Considerable effort was focused on minimising the possibility of biasing interviewee responses.

The schedule began with a vignette to which interviewees were asked to respond at length. This vignette concerned a homeless young adult with a mental illness. (Further details are set out in the next section, as much of the material for the current paper is derived from responses to this vignette.) A middle section of the schedule comprised specific response items, questions that appeared relatively neutral to the relational aspects of health. Finally, increasing in directness in the second half of the schedule, items explicitly asked interviewees to discuss relational aspects of health, including the possibility that humans may be considered relational entities.

Proceeding from a post-structural and constructivist premise, I recognise that questions are inevitably ‘interven- tive’ (Tomm, 1988). That is, if a direct question is put to interviewees, a question that specifically reflects the interests of the project, this will tend to have the effect of imposing the terms within which interviewees frame their responses. To counter this possible bias the vignette, in particular, offered interviewees a ‘blank screen’ upon which ideas and assumptions about health and well-being, pathology and disorder, could be projected. Indeed, one of the guiding comments given to interviewees was to ‘imagine you had a magic wand’. Interviewees were free to give voice to their ideas about what it is to be human: what our nature is and what our needs are.

Each of the interviews was transcribed and the transcript was subjected to both content and thematic analysis (Denzin & Lincoln, 2005). The content analysis involved a linear and deductive engagement with the data: for example, counting how many comments were directed to ‘families’, or ‘social ties’; what proportion of the overall content did each of these categories comprise, and what proportion did they jointly occupy; were there variations in quanta between the two cohorts, and so forth.

The thematic analysis sought to find whether there was a pattern, or patterns, present across the set of interviews.

That is, what stance do practitioners take with respect to interpersonal relationships in their thinking about their clinical practice?

‘That is, what stance do practitioners take with respect to interpersonal relationships in their thinking about their clinical practice?’

Mark Furlong

 clients’ intimate relationships? More particularly, how do practitioners factor their clients’ past, present and future social connections into their work?

These questions have fascinated me for many years and I recently undertook a low-tech, empirical project to understand their workings more fully. This project set out to access the accounts of practice offered by two professional groups, the first comprising (self-defined) psychotherapists in private practice, and the second an equal-sized cohort of case managers working within the public mental health service. These practitioners were not selected on the basis of an allegiance to family therapy, or to any other therapeutic modality. On the contrary, it was intended to access a sample of practitioners who varied with respect to discipline of origin, theoretical allegiance and level of professional experience.
that, for example, referenced ‘families’ and ‘social ties’. I sought to discern how the interview data as a whole responded to the basic question the research set out to investigate. When the 22 transcripts were collectively considered, this data revealed ‘clusters’ of material which had not been anticipated. To make sense of these unexpected results, as well as those that were more expected, I undertook a further round of interpretation.

The Interview Process

With two exceptions, all interviews took place in the interviewees’ workplaces. Each interview was audio-taped and was between 45 and 70 minutes in length. Some minimal notes were taken during the interviews yet such in-the-moment recording was a second level of priority, as my central concern was to be encouraging and attentive. Notes for each interview were written up immediately after each interview, or as close to this time as possible.

Without exception, interviewees seemed engaged and thoughtful. As was expected, some interviewees were more comfortable with ‘taking the floor’ and offering apparently measured, well-structured responses while others made more anecdotal, less formal commentaries. As the questions increasingly engaged with the possibilities of a relational orientation to self, health and pathology, inviting less technical and more personal responses, the tone of the exchange tended to become more intense. Often, in this latter phase, interviewees were prepared to offer their views on ethical and philosophical questions. This turn required some real daring as the summoning-up of these personal opinions took the interviewees a long way from the technical knowledge that is so much easier to recite.

Results

Analysis of the key research question (see above, under subheading ‘The Project’) generated a clear pattern: interviewees rarely presented clients as embedded, relational entities. On the contrary, clients tended to be viewed, often quite exclusively, as autonomous beings, whose capacity to be in charge of their life was (more or less) flawed. This finding held for both the private psychotherapists and for the mental health workers, even though the latter group appeared to consider the relational somewhat less than the former (at least when responding to the vignette).

Within the limits of this article, it is not possible to detail the results obtained from each of the schedule items and from the larger, more inductively derived interpretations. However, two particular findings convey the ‘drift’ of the overall results, as well as speaking directly to the established concerns of many family therapists. The first of these findings was generated from the analysis of the vignette.

The ‘Lennie’ Vignette

After introductions, interviewees were given a copy of a 400-word vignette, which presented a ‘problem-saturated’, but not immediately urgent, account of ‘Lennie’, a 27-year-old man of Italian background. In this scenario Lennie is currently homeless, has a long-standing diagnosis of schizophrenia, and is understood to be ‘treatment resistant’. Interviewees were asked to consider ‘possible short, medium and long-term treatment goals’, as well as the question ‘what does Lennie need?’ on the basis that there are ‘no current issues of risk’, ‘no resource limitations and you had a magic wand’.

Within the vignette were a number of cues to possible longer-term ‘significant-other relationships’, most obviously where ‘family’ and ‘culture’ intersect (Lennie was stated as being of Italian background and bilingual). The vignette included the information that he gained his first paid work via a family connection, lived at home for five years after his initial diagnosis of schizophrenia, and has older brothers and a younger sister, people who are likely to be interested in his welfare and who are potential, perhaps even are currently, resources to Lennie. Also, the written notes record that Lennie initially saw an Italian-speaking psychiatrist.

Asking interviewees to comment on a client like Lennie, someone who occupies a chronically marginal position, was designed to invite an engagement with his social exclusion: given there was (in the vernacular of mental health) ‘no risk to self or others’, and that there were no restrictions on resources, I expected the vignette would trigger the practitioner’s interest in the full spectrum of possible ‘significant-other relationships’ beyond those that are related to his membership of a particular family.

In the vignette, as in actual practice, such an interest could be expressed in more or less creative ways; for example, associations and identifications that are generated around ‘club’ or special interest groups; friendships catalysed by way of paid, or unpaid, work; by activating, or reactivating, traditional, albeit perhaps extended, family ties or by a combination of these domains. Especially for the publicly employed mental health interviewees (a group we might expect to have been sensitised to the benefits of different kinds of social attachment by current policies and research), I had assumed that the Lennie scenario would be a ‘Rorschach’ upon which a reasonably fertile ‘imagining of the intimate’ might be projected.

So, what did the interviewees say about the vignette? (see Table 1).

All instances, however brief, where ‘relational aspects’ of Lennie’s needs or goals were mentioned in the 22 interviews were counted. The results were:
• five among the 11 mental health interviewees
• six among the 11 psychotherapeutic interviewees
• overall total: 11/22.

Of these 11 instances, two interviewees (MH 11 and PT 5) discussed both the enhancing of informal ‘social ties’ and the possibility of consolidating or re-establishing contact between Lennie and some/all of his family. That is, there
were a total of 13 instances where aspects of the relational domain were specified, with only two interviewees mentioning both ‘social’ and ‘family’ aspects.

Counting Instances
Saying that half of the interviewees (at least) noted that there were, or could be, relational aspects potentially relevant to the ‘Lennie’ scenario is to present a fact. Yet, this bald fact can be elaborated. Below, two tables set out the proportion of content concerned with ‘comments about family and social relationships’ in the 22 interviews. This material provides an impression of the contours of the conversations, if we concede that a binary division between content as either ‘category A’ or ‘category Z’ does not necessarily represent the data well.

A closer reading of the mental health interviewees’ pattern of response to the vignette indicates some evenness in these accounts. And, among the group that did acknowledge social contexts, interviewees seemed to discuss the importance of relationships in similar ways, with one exception (MH11). MH11 was the only ‘outlier’ — putting forward a considered, even complex, approach to the possibility of family work.

This apparent evenness was not found with the psychotherapist sub-group (see Table 3).

### TABLE 1
What Did Interviewees Say About Family and Social Dimensions of the ‘Lennie’ Vignette?

<table>
<thead>
<tr>
<th>Mental health worker</th>
<th>Question: Were ‘relational aspects’ discussed with respect to needs/goals in the Lennie vignette?</th>
<th>Psychotherapist Question: Were ‘relational aspects’ discussed with respect to needs/goals in the Lennie vignette?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>No mention</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suggested ‘working with the family, supporting the family, maybe getting him connected back with the family, educating the family and helping them understand him a bit more’</td>
</tr>
<tr>
<td>2</td>
<td>No mention</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No mention</td>
</tr>
<tr>
<td>3</td>
<td>No mention</td>
<td>3</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No mention</td>
</tr>
<tr>
<td>4</td>
<td>Very briefly noted a non-specific goal ‘It might be possible for Lennie to reconnect his family about schizophrenia (and try to) get the family on board’.</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Raised as a specific goal ‘putting’ some time and effort into family, educating the family about schizophrenia (and try to) get the family on board’.</td>
<td>5</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>No mention</td>
<td>6</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7</td>
<td>Very briefly noted the idea of ‘linking’ him into some sort of social networks because it sounds like he’s fairly isolated</td>
<td>7</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>No mention</td>
<td>8</td>
</tr>
<tr>
<td></td>
<td></td>
<td>As a long term goal: to ‘integrate him back into some family support and housing’</td>
</tr>
<tr>
<td>9</td>
<td>Noted that ‘having some sort of contact with his family again (might be a goal) because (the absence of contact) would be a continual grievance for him’</td>
<td>9</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>No mention</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No mention</td>
</tr>
<tr>
<td>11</td>
<td>(i) Articulated as a medium term goal, to assess ‘how much of a relationship has he got with the folks and the rest of the family, (and to see) how things might even be improved’; (ii) articulated as a long term goal ‘(to be) linked up well with the community in general, you know to a couple of clubs and groups and … friends’.</td>
<td>11</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suggested the goal of further assessment in order ‘to know a lot more of the detail, (including that concerned with) family culture, about migration, the possibility of the client being bilingual, and so on’.</td>
</tr>
</tbody>
</table>
In Table 3, several ‘outlier’ interviewees tended to shape the overall percentage figures. For example, it is clear that two interviewees (PT 11 and PT 9) are both systemic in orientation and are also sophisticated in their application of multiple knowledge streams. PT 1’s transcript does not specifically engage with the difficulty presented in the vignette, but offers general comments to the effect that ‘all he (Lennie) needs is a sense of belonging’.

**General Comments**

In spite of the fact that the presented vignette was reasonably complex, every interviewee took care to respond at considerable length. Typically, this commentary resulted in at least one transcribed page of data, usually one where many different kinds of goals were suggested and where complex reflections were offered on the challenges with which practice would have to engage. There was a great deal of difference in the structure of the commentary, with some interviewees formally offering short, medium and longer term ideas, whilst others put forward ideas of a more anecdotal nature. However, the amount of ‘content’ that could be identified within the broad category ‘concerned with the relational’ was strikingly modest. This was especially the case with respect to ‘social ties’, that is the non-familial aspects of the relational dimension (two respondents out of 22). Overall, it is not unfair to say that an interest in the relational dimensions of Lennie’s life was not extensive. Whether such an interest was associated with statements about goals, or arose as part of an informal conversational commentary, the majority of the interviewees had little to say about relationships.

**Tone**

Although 11 interviewees mentioned Lennie’s family, this sometimes occurred in such a way as to appear insensitive or even blaming. Thinking about, and contact with, families is not always ‘family sensitive’. Although it is inevitably difficult to interpret ‘tone’, close attention to the 11 instances of family-related goal-making revealed several themes. For example, some interviewees seemed both compassionate and culturally sensitive, whereas others seemed not only naïve and ‘Lennie-centric’, but also judgmental; for example, ‘He did have his connection with the family (until) the family kicked him out’. This is a slighting comment, as the vignette makes it clear that Lennie had been ill for (some or all of) the five years between being diagnosed and leaving home. Over this period, it is more than likely he had been hard to live with, perhaps even accusatory or dangerous. Saying he had been ‘kicked out’ implies that the speaker is unashamedly aligned with Lennie: what of the chance that his relatives, most likely his aging parents, were unsettled, burdened and/or worn-out by this time?

Moreover, if his relatives had been in contact with the mental health authorities, the chances are they would have been advised to stop ‘colluding’ with him by allowing him to stay at home without medication and behave irresponsibly, or by not challenging him, etc. Also, even if someone with a psychiatric disability is not living with their family/a family member, it should not be assumed that family members have no practical and/or symbolic relationship with that person. In this case, the written case details did not say Lennie had no contact (and the research is clear that there is likely to be supportive contact even if the person with a mental illness is not living with relatives). Most interviewees who said something about Lennie’s family assumed he had no contact and were therefore ‘Lennie-centric’, perhaps even implicitly ‘family blaming’ in that assumption.

Such an asymmetry was apparent in a number of comments. For example, one interviewee stated that ‘having some sort of contact with his family again (might be a goal) because (the absence of contact) would be a continual grievance for...’
him'. Yes, it does seem likely that Lennie would be troubled by an absence of contact with his relatives; yet it also follows that this absence, if indeed there is an absence, would also be intensely felt by his parents, siblings and broader extended family. Is it possible to imagine any family, perhaps especially an Italian family, not being deeply troubled in having one of their number chronically ill and living out on the street? This would be likely to be awful for Lennie, it would also be likely to be traumatic for those with whom he is related. Unlike the above comments, which are at best one-sided, there were only two interviewees who expressed an overtly compassionate attitude towards Lennie's family.

**Affection and Belonging**

As well as asking the interviewees to consider their goals for Lennie, the written material given to the interviewees used the word 'need' — ‘What does he (Lennie) need’—as I did too, in my spoken introduction as interviewer. Among the dozens of declarations about what Lennie might want or require only one interviewee (PT 1) offered any comment that Lennie might ‘need’ to be loved and might benefit from having a sense of belonging. It was frequently stated that Lennie needs ‘medication’, ‘to be (therapeutically) engaged’, and/or ‘somewhere safe to live’ but — PT 1 to one side — no one chanced the view that ‘He might need a mate or two’, or that he might ‘benefit from being valued’, or that ‘Like the rest of us, what Lennie needs is everyday care and affection’.

Nearly every interviewee used the word ‘need’, or its equivalent (‘requires’; ‘has got to have’, and so on) and most did this with some frequency — ‘He needs a safe place to live’; ‘What he really needs is assertive outreach’, ‘Yes, a CTO (Community Treatment Order) might be required’, and so forth. Yet, these claims were not complemented by similarly phrased invocations of the importance of friendship, respect, affection, or the like. This is not a little surprising.

Overall, interviewees did not express an interest in, let alone an allegiance to, current research and policy that emphasises the importance of improving clients’ sense of social inclusion. In addition, there was little attention given to the cultural dimension of Lennie’s situation. What I also came to see as particularly interesting was that interviewees often placed their own relationship with the client at centre-stage. This pattern was present in their responses to the Lennie vignette, yet it was also evident across other items in the interview schedule. An elaboration of this second finding is set out below.

**‘Working Relationally’**

As noted above, the ‘relational’ dimension of Lennie’s life was generally not pursued as a high-priority category. Much more frequent in these accounts were references to what might be termed the ‘therapeutically relational’. That is, in so far as the prospects for good outcome and client well-being were indexed to any one factor in their accounts, the single most cited variable was that of ‘the relationship’.

Interviewees highlighted ‘the relationship’ in statements which emphasised the importance of ‘engagement’, as in ‘the therapeutic engagement’, or embedded it in sentences that referred to the practitioner’s obligation to contain the client’s dependence and vulnerability. Perhaps most simply, they repeatedly invoked the term ‘the relationship’, meaning ‘the helping, therapeutic relationship’, as a key point of reference. When questions cued discussion of practice, and particularly when interviewees were asked to discuss a ‘successful example of your practice’, with only one exception it was face-to-face practice between participants that was reported as being the cornerstone of success and professional satisfaction. Similarly, it was often stated, and stated as if it was a self evident truth, that a ‘meaningful’, ‘real’, ‘deep’ engagement was a condition that had to be achieved if progress was to be made. When interviewees were asked, in the middle of the interview, the question ‘Are relationships important to psychosocial health and well-being?’ several interviewees simply forgot (elided?) that the context of this enquiry at that time concerned ‘family and friends’ and responded that ‘Yes, the (therapeutic) relationship’ is crucial.

Not only was the therapeutic relationship the variable most commonly cited, but the tone of these repeated references was invariably positive, with a sense of legitimacy, if not of pure contentment, albeit sometimes with a complicating nuance: for example, that it could be unpleasant to get close to some clients; that one could sometimes feel impotent and exploited in these relationships; that the work could be exhausting.

One particularly complex example of a commitment to the ‘therapeutic relationship’ was offered by a mental health interviewee:

‘([I]t is satisfying work — the person that I told the good story about, she came up to me and said “I love you” and it was great, and it was kind of sad. These people only have us (i.e. the professional staff). They usually don’t have families or friends.’

This is a compassionate statement made by someone is deeply involved with their work. Yet, this comment also raises a number of difficult questions. For example, it is unlikely to be true that this client, and indeed all clients, do not have, or might not have in the future, significant contact with anyone at all apart from their worker or therapist. And, at a different level of analysis, such a statement might denote the presence of an ambiguous, and not necessarily entirely positive, dynamic between practitioner and client.

The key difficulty is that this comment may reflect a self-perpetuating attitude: who can really say that someone who at present has ‘no family and friends’ is sentenced to this forever? The assumption that this state is permanent precludes the possibility of change, a stance that results in the case planning process being denied the quality of ambition. Moreover, it has the effect of encouraging dependence in the client and, I suspect, of embedding the discomfort, even rage, that such dependence provokes.
What is at issue here is that ‘therapeutic engagement’ or ‘the relationship’ is not an end in itself. On the contrary, ‘the relationship’ is a necessary, but not a sufficient, condition for a positive outcome. What is needed from a practitioner is a modulated, considered and minimal repertoire of intervention. As Paterson (1996) has argued, the practitioner–client relationship should be circumscribed in intensity, duration and ambit. For example, in some variations of the practitioner role — such as being an effective problem solver, teacher-coach or advocate — it is often not necessary to have an intense relationship with a client. Broadly, the therapist should not be relationally intrusive, especially if such an involvement will not be sustained over the longer term. Nor is it sensible to foster (more) dependence than is required, nor create vulnerability. In brief, relational intensity is not a sine qua non; rather, the kind of relationship should be appropriate to the goals of practice with specific clients.

If the goal, or if one of the goals, is to strengthen significant-other exchanges between clients and their (potential) network of family and friends, this requires a flexible, more or less intense kind of relationship with the client. Such a positioning is dependent on the characteristics of the client and their social ecology, both currently and as it might be potentially. In contrast, if there is an assumption that the worker–client relationship is the centre of, rather than the vehicle for, the professional work, this will tend to configure what actually occurs even if the practitioner’s ‘espoused theory’ speaks of something different (Argyris & Schon, 1976).

It is often said in research that ‘association is not causation’. Certainly, the current study provides no grounds for proposing a necessary causal linkage between practitioners’ frequent citing of ‘the relationship’ and their relative inattention in these interviews to the clients’ social relationships. This said, a case can be made for this linkage as a matter of logic: in so far as practitioners assume that ‘the relationship’ has primacy, they are less likely to imagine adequately, and pay attention to, what may be possible for the client beyond the consulting room. And, as they discount or ignore the clients’ prospects for the interpersonally intimate, their approach approximates the ‘therapocentric’ (Furlong, 2000).

Of course, such an interpretation does not disqualify the importance of quality worker–client relationships in practice. Emotionally literate and reflectively undertaken professional–client relationships are essential to good practice, providing that we remain aware ‘the relationship’ has to combine aesthetic and pragmatic dimensions (Keeney, 1983). As straightforward as this line of thought seems to its believers, a minor difficulty remains: what should these relational ensembles be called? In the past, a colloquial term was ‘kith and kin’; now, perhaps the most common everyday term is ‘family and friends’. Academically, no convergent frame unites, for example, those that are interested in ‘families’, in ‘group work and group processes’ and in ‘social networks’. In this way, human connectedness defies easy categorisation: it is as spontaneous as it is patterned, as singular as it is persistent. ‘Belonging’, in part, to research disciplines like sociology and anthropology, cultural studies and psychology, and, in part to the applied disciplines, such as family therapy and the family-work component of mental health and child protection: the relational belongs to no single discipline.

As happens in any social site, ‘the locals’ — in this case the sample of therapists and mental health workers — ‘naturalise’ much of their milieu. Key among the taken-for-granted elements of mental health and psychotherapy is the assumption that a client is a stand-alone entity, a phenomenon that Pierre Bourdieu argues masks the intensely ideological nature of the category ‘the individual’ (Branson & Miller, 1992). On this level of social analysis, the pattern of professionals concentrating in particular ways upon ‘my client’ is entirely consistent with received ideological and practical sense.

That is, the convention that it is ‘the individual’ that constitutes the proper locus for investigation and remedial attention does not originate in the organisations and training institutes that graduate society’s professionals. Rather, it is derived from our larger cultural and ideological context. This line of influence determines that the organisations and training institutes authorised to turn out professionals will do so in just such a way as to reproduce ‘our’ cultural bias in favour of a mode of thought based on the individualisation of the social realm. It is then seen that the ‘neutral’ psychotherapeutic and mental health experts, those that have ownership of that which is objective and technical, have confirmed that it is ‘the individual’ who is the proper subject for attention.

Captured by the Game?

Research on social networks, social capital, social exclusion and social epidemiology suggests that a person’s well-being, quality of life, mental health, even resistance to, and capacity to recover from, disease is indexed to the quality of that person’s interpersonal life. These webs of relationships comprise linkages that are intimate, at the same time as they are also more or less traditional. This applies whether a person is a formal ‘service-user’ or an ‘ordinary’ community member. None of this is new to systemically oriented practitioners. That is, the recent rush of empirical research confirming the importance of interpersonal connections has probably had no greater effect on this ‘tribe’ than to offer a degree of symbolic acknowledgment, as a statement of indirect vindication for beliefs that were once put down as ‘soft’, or even ‘hippie-like’. Contextual and family therapists know that their group was built upon the premise of human interdependency, a premise that became a root metaphor decades ago.

As straightforward as this line of thought seems to its believers, a minor difficulty remains: what should these relational ensembles be called? In the past, a colloquial term was ‘kith and kin’; now, perhaps the most common everyday term is ‘family and friends’. Academically, no convergent frame unites, for example, those that are interested in ‘families’, in ‘group work and group processes’ and in ‘social networks’. In this way, human connectedness defies easy categorisation: it is as spontaneous as it is patterned, as singular as it is persistent. ‘Belonging’, in part, to research disciplines like sociology and anthropology, cultural studies and psychology, and, in part to the applied disciplines, such as family therapy and the family-work component of mental health and child protection: the relational belongs to no single discipline.

This is so because one feature that is consistently present in relationships is their subjective character: who I really relate to is the person with whom I experience myself as having a meaningful bond, and this might not be with one, or any, of my siblings. One’s closest person, or set of persons, cannot be predicted: it may be with a parent or a
partner, but it just might be with a next-door neighbour or a now-deceased ‘aunt’ — someone who, in fact, was never really an aunt at all. Perhaps, my closest link is with a group — like a scouts group or a rave club. This is fine, ‘It’s all good’ as is said these days, but what if my most intimate, meaningful connection is with a therapist, that is with a person who is paid (more or less directly) to relate to me?

And, making this circumstance potentially more than a little tricky, what if this therapist is of a professional culture that emphasises that the centrality of the client–therapist relationship is the sine qua non for effective work, that the exemplary quality of this engagement between client and therapist is the base upon which the project stands or falls? Last, but not least, what if one more variable is included in this complex, but not necessarily contradictory, equation: that the therapist’s ‘espoused theory’ (Argyris & Schon, 1976) places an abiding value on the importance of a client’s ‘significant-other relationships’, on the enduring, and yet evolving, milieu that is the client’s interpersonal gestalt beyond the consulting room?

It is possible that dynamics played out between these propositions could be more fully observed, specifically the possibility that a therapist’s allegiance to the therapeutic relationship might cause some tension with their allegiance to the ‘espoused theory’ (Argyris & Schon, 1976) of using this relationship as a means to improve the client’s significant-other relationship outside of the therapy. This is not simply an ‘academic’ question.

According to Hugh MacKay, perhaps the highest profile social researcher in Australia, around 5% of the population — that is around 1 million from a population of approximately 20 million — meets with a counselor/therapist at least once a week (MacKay, 2002). In these sessions the counsellor is likely to be at least non-judgmental, if not offering the kind of ‘unconditional positive regard’ that is learnt in counselling training. This relationship is asymmetric as the (paid) other person listens closely all the time and doesn’t demand half the airtime; this person is ‘on the client’s side’, expected to advocate that their client get more of what s/he wants. This will feel safe and loyal to the client but, at a second level, does this teach the client to be less other-oriented and more ‘me-first’?

Clients who have experienced ‘the (therapeutic) relationship’ as a ‘stand-alone’ factor in their lives might find that this experience inadvertently undermines the prospects for improving their more significant other-contacts. As the strategic and systemic authors of the late 1970s and 1980s clearly articulated, once a dyadic relationship between a therapist and a client forms a stable boundary, the emergent sub-system tends to be exclusive in its operations and homeostatic in its outcomes. In this way might the therapeutic allegiance to ‘the relationship’ have the effect of constructing clients who yearn to be autonomous yet who are also learning to be less capable of maintaining the give and take of equal relationships?

Endnotes
1. The term ‘significant-other relationships’ has been used as a deliberately inclusive, albeit awkward, term to fuse kith and kin, family and friend, relationships. Such linkages can only be defined in phenomenological terms. When, and how often, do participants see each other is not necessarily important, nor whether they live close to each other (see Furlong, 2001).

2. The relatively well-established tradition of ‘relational psychoanalysis’ was referenced as a key motif by one interviewee. Although this frame has become increasingly popular since its introduction by Greenberg & Mitchell (1983), for the purposes of the current study its nomenclature presents as a clear complication: in so far as the phrase ‘relational psychoanalysis’ is accepted and circulated, this phrase tends to conflate the ‘socially relational’ aspects of human life with a far more limited construct — the ‘therapeutically relational’. Such a conflation is counter-intuitive in so far as it appropriates to the clinical realm that which ‘belongs’ to the larger, non-contrived, non-commercial domain of personal relationships. Pozzuto and Arnd-Caddigan (2006) further discuss this point.

3. The cachet associated with ‘the relationship’ is powerful yet, I contend, is also perverse. In the first instance, ‘the relationship’ is simply a commodity, a fee-for-service exchange. Yet, concurrent with its commercial basis, ‘the relationship’ is endowed with a special valence given its association with the quest for ‘the corrective emotional experience’ (Alexander & French, 1946), a process which both characterises and ennobles the therapist and their mission. This conjunction makes for an awkward contradiction, one I believe many prefer to ‘sanctify’ rather than experience. Like the role of temple prostitutes in ancient Lebanon, the role of the therapist is difficult to see clearly given it has a cultural brilliance as a key means to achieving a secular form of redemption. (Thanks to Paul Gibney for the Alexander & French reference.)

References


---

**Subscription Reminder**

‘… I saw that one must oneself be a patient, and a patient among patients, that one must enter both the solitude and the community of patienthood, to have any idea of what “being a patient” means, to understand the immense complexity and depth of feelings, the resonances of the soul in every key — anguish, rage, courage, whatever — and the thoughts evoked, even in the simplest practical minds, because as a patient one’s experience forces one to think.’

(Oliver Sacks (1986), *A Leg to Stand On*, London, Picador, originally published by Duckworth, 1984.)

We hope that reading the *ANZJFT* entices you to think, rather than forces you!

Send your subscription form to the Subscriptions Manager by January 1 each year:

Send your form to the: Subscriptions Manager

49 St Louis Drive

Port Sorell TAS 7307

Ph. 0410 069 524 bh 03 64 287958 ah

journalsubs@anztjft.com

or www.anzjft.com

And tell her about your address change!

Visit our site: www.anzjft.com

Institutions subscribe via: info@australianacademicpress.com.au