How to lose your clinical balance, while holding on to your therapeutic bearings, and other ideas on working therapeutically with a ‘treatment resistant’ client diagnosed with Borderline Personality Disorder

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This article describes a clinical case where an Advanced Brief Strategic Therapy Model (Gibson and Boardman, 2016; Gibson et al., 2014; Nardone and Watzlawick, 2005) was used with a woman presenting with presumed Borderline Personality Disorder (BPD). In the world of therapy, the process of change can often be hard to predict at the best of times and extremely unpredictable during the worst. It can be difficult for the curious therapist to know how and what to look for as indicators of change when the larger picture may appear to remain unchanged in a client’s life. I am curious about those therapy cases which present with great difficulties attached to them and which often drain much of our energy, vim and vigour as psychotherapists with often little apparent return on the investment we make. That is, if we measure that return in terms of reported change by the client, as opposed to privileging therapeutic disposition.

Practitioner points

- This article explores how an Advanced Brief Strategic Therapy Model was used with a client diagnosed with Borderline Personality Disorder
- I critique the often misunderstood idea of embodied cybernetics as an interpretation of the therapeutic process
- Drawing on clinical practice, I describe some of the challenges in working with a client who often dispensed with rationality and employed non-ordinary logic in her modus operandi

Keywords: Advanced Brief Strategic Therapy; cybernetics; borderline personality disorder; non-ordinary logic.

You cannot reason someone out of a position that they have not been reasoned into in the first place. (Jonathan Swift)

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Psychotherapy is not sought primarily for enlightenment about the unchangeable past but because of dissatisfaction with the present and a desire to better the future. (Milton Erickson)

Introduction

This article will describe a clinical case where an Advanced Brief Strategic Therapy Model (ABST) (Gibson and Boardman, 2016; Gibson et al., 2014; Nardone and Portelli, 2007; Nardone and Watzlawick, 2005) was used with a woman presenting with presumed Borderline Personality Disorder (BPD). In my experience this client’s presentation is consistent with that of many clients who report having been diagnosed with BPD. According to the National Institute of Mental Health (NIMH), BPD is a serious mental illness marked by unstable moods, behaviour and relationships. Most people who have BPD suffer from problems with regulating emotions and thoughts, and impulsive and reckless behaviour, in addition to experiencing unstable relationships with other people (Gunderson, 2007; Lenzenweger, 2007; Lieb et al., 2004; Linehan et al., 2006; Paris et al., 2004).

I will endeavour to reflect on many of the challenges in this case which made huge demands on the therapist to adapt to a client in chaos. This client did not stay on any theoretical page – she kept jumping off it. The therapeutic dilemma I was faced with was whether I should cling to my theories or follow the client.

How do we hold on to our therapeutic bearings when the ground underneath is so uncertain? How do we measure what clinical success looks like when the path is so often such a crooked and circuitous one?

The therapeutic approach that was used with this case presentation fits within an Advanced Brief Strategic Therapy Model (ABST). The work with this client, however, was longer than usual, as typically this work lasts on average six to eight sessions. Within the ABST model there is the creative room to adapt to the needs of clients. When the number of sessions is higher, as was the case with this particular client, it followed that the client had reported that therapy was helping them to make changes in their life that had previously eluded them.

ABST evolved out of a fruitful collaboration between Paul Watzlawick and Professor Georgio Nardone that spanned two decades and builds on the pioneering work of the Bateson team, the Mental Research Institute and the Brief Therapy team involving Watzlawick,
Weakland and Fisch. Dr Padraic Gibson has evolved this work and we were both part of a research team who have had an outcome study on using ABST with OCD published in the British Medical Journal in 2016. Dr Gibson first introduced this work to Ireland having trained with Professor Nardone in Arezzo, Italy (Gibson et al., 2014).

Cybernetics: from interpretation to interaction

If you have any experience of working with clients who have been diagnosed with BPD you will, I am sure, be familiar with the concept of ‘treatment resistance’. This is perhaps therapeutically comparable to trying to mobilize someone to make changes they would like to make (in theory) but in practice seem resistant to. This brings to mind the myth of Sisyphus who was condemned to push a heavy stone up a hill, only for it to continuously roll back down again.

Often in our clinical experience with difficult cases the therapist ends up working harder and harder trying to effect change. This then usually increases the client’s ambivalence or resistance to changing. Embodied cybernetics extends an invitation to the therapist to allow oneself to be changed by the process of therapy in order for the client to change. This requires a paradigmatic shift away from higher order cybernetics serving as an interpretation of the process, towards inhabiting the circular interactive relational space between the therapist and client (Keeney and Keeney, 2012).

As family therapists we are invited into an embodied interactive dance with our clients: a circular recursive process which privileges interactivity rather than interpretation (Keeney and Keeney, 2012). When considered in this way the therapeutic process is seen as circular in nature: ‘I am with you as you are with me as I am with you’. I remain open to the same process which I am inviting a client to open themselves up to, namely, changing in order to change.

Therapy does not always stay between straight lines and this is particularly so with very complex cases where clients employ non-ordinary logic to fuel a problem. So what happens when a person we are working with acts outside of a linear, rational construction of reality? Do we bend their reality to fit our theory or are we prepared to amend our theories (Gibson and Boardman, 2016).

I find that clients generally want to know ‘why’ something has become a problem, in order to try to resolve it. It is not because they think there is anything virtuous in acquiring insight – it is more that they have been
encouraged to believe that they need to know ‘why’ before they can resolve a problem. I suggest to clients that finding an answer to the ‘why’ question is what they discover after they have changed but not before. Knowing ‘why’ something is a problem is the booby prize clients are left with when they remain unchanged. Fleming warned against ‘the tyranny of niceness’ (Milne et al., 2011) which can choke the practitioner in the helping professions from adapting to the needs of clients.

A point in case

I work as a senior family therapist and supervisor within a community-based psychotherapy and consultation service. Referrals are assigned to therapists as space to take a new client becomes available. Unless a client has made a specific request, they are paired with the next available therapist.

I met both Mary and her only child, 13-year-old Susan, during the first session. Susan had continued linking in with Child and Adolescent Mental Health Services (CAMHS) during the previous two years. She had struck up a good relationship with her key worker during this time. Although I only met Susan once, she did maintain regular contact with CAMHS in parallel with the work I undertook with her mum. They both agreed that the reason for referral concerned their relationship with each other, which was indeed fraught with tension and strife. Mother and daughter both wondered aloud whether their relationship was beyond repair.

Susan had never met her father Toby and had acquired very little information about him. She was aware that Toby and her mum had a brief relationship. She knew the name of the island that her dad was from and attributed her great physical strength and athletic prowess to her Dad’s genes. Aside from being an only child, Susan was not in regular contact with extended family members or relatives. She expressed that she felt that her Mum had burnt most of the relational bridges between her and her relatives by falling out with nearly everyone.

Mary described her life as a slow motion car crash. She believes her parents were not there for her growing up. Additionally, she feels that they both launched a self-fulfilling prophecy when she was a young girl that she would ‘never amount to anything in life’, a prophecy which Mary concedes that she fulfilled.
Mary recalls that both her parents demonstrated a long-term commitment to drinking. She feels they drank excessively with little thought of the impact this had on their family’s functioning. Their contempt and bitterness towards each other created a pattern of fighting and acrimony that forged a double-edged sword: on the one hand it kept them very close in their ‘dysfunction’, but on the other hand ensured little in the way of intimacy in the couple’s relationship.

Mary is quite struck (stuck) by the thought that even though she bore witness to her parents’ ‘madness’ (although logically she imagined that she would run from this in her own life), she has also followed them down the rabbit hole. This description, to my mind, echoes those lines of terrifying bleakness that Hans Ark uttered in his poem printed in a short-lived Dadaist magazine (Schaeffer, 1968):

The head downward, the legs upward,
(s)he tumbles into the bottomless from whence (s)he came

Mary has taken on what she described as an ‘attack first, ask questions later’ relationship disposition. She appeared comfortably habituated as she described her instinct to obliterate one relationship after another. Now in her 40s, Mary’s litany of disastrous relationships stretches back over thirty years. No one has been spared as her trident-like rage leads her by the hand down another dead end road, masquerading as a friend but disguised as a silent assassin with the dagger under his cloak.

Little imagination is required to understand how difficult it is to attempt to engage therapeutically with clients like Mary. She is the proverbial walking paradox . . . that which she attests to wanting in life . . . she ensures through her action she will never get.

How do we measure what progress or success even begins to look like in an infinitely complex case like this? With a client who offers so many invitations to the therapist to end the therapeutic work (and often for good reason!) but on the other hand, their capacity to maintain enduring change appears extremely limited.

When the therapeutic relationship gets up close and personal

I had been working with Mary for almost ten months and had seen her nineteen times during that period. Mary described how therapy was slowly helping her to make the changes that she had wanted to make but which heretofore had eluded her. Although for most clients ABST is usually a much shorter piece of work, for some, longer
therapeutic work is required. The model affords this flexibility as it does not try to shoe-horn clients into solutions but rather seeks to adapt to the client’s needs.

At the time of referral, Mary’s difficult relationship with her daughter Susan was the designated problem. The initial therapeutic focus was aimed at Mary’s emotional instability and the way it created the conditions for unstable relationships and a volatile home life. This woman’s life was hallmarked by one drama superseding another. Mary clearly enjoyed breaking ‘the rules’ wherever she met with them, whether this was at home, in work, with neighbours, teachers or anyone else in authority. She thought that ‘the rules’ were only for ‘suckers, nice guys or saps’, people she would describe as pathetic and weak.

Mary described a pattern of unstable relationships with everyone she knows, including a number of ex-partners who, she suggested, were no good for her and had only used her. The turnover of people in her life was exceedingly high. She described how initially a new relationship would blossom full of hope. However, the early signs of spring would give way to a heavy winter as the early promise morphed into despair.

**There are none so blind as those who will not see**

This client’s presentation brings to mind the idea that: ‘We first raise the dust and then complain we cannot see’ (Watzlawick et al., 1974). Mary also reminded me of the person who was asked: ‘Now that you have broken through the wall with your head what will you do in the neighbouring cell?’ (S. J. Lec in Watzlawick et al., 1974). The paradox of self-deception is that the person gets to be both the deceiver and the deceived.

I have observed that many clients who seek our help in therapy appear unable to take the help we offer. These clients usually feel ambivalent about changing. Many like the idea of changing in theory, only to find they are less committed to the process of change. This ambivalence is illustrated through the following construct: ‘change me without me having to change’.

Instability was one issue that Mary consistently highlighted. This instability affected her emotional functioning and her capacity to develop and keep healthy relationships. To my mind, it was as if a
metaphorical invitation was extended from the client, to me as the therapist, to join her on an emotional roller coaster.

I have learned during my two decades of clinical experience that clients such as Mary require a particular type of relationship where the therapist takes responsibility to facilitate the client changing. This kind of relationship is rarely strengthened by a therapeutic stance which construes the therapeutic milieu as one where the therapist takes a back seat with no sense of therapeutic direction, in the hope that change will mysteriously happen.

Many family psychotherapists believe that some emergent quality which is dialogically driven will arise through our clinical work and that this will serve as a catalyst for clients changing. This follows in what Hoffman calls ‘the interpretative turn’ (1991). It may also be presumed then that this interpretative process will facilitate steering the client away from redundant patterns towards more desirable ones.

For family therapists who have espoused this view, the feedback loops of cybernetic systems are replaced by the inter-subjective loops of dialogue. The central metaphor for therapy thus changes to conversation. (Hoffman, 1991)

I have found that clients appreciate having a conversation about who is responsible for change during the process of therapy. Most of my clients have expressed a preference for a process that has an end in mind, which commences with a sense of direction. I contend that if we direct our clinical practice nowhere in particular, we will be left feeling that we are losing our therapeutic bearings and the aforementioned ‘tumbling into the bottomless’ may take on an eerie familiarity.

Milton Erickson reminds us of the curious paradox at the heart of traditional therapy where the therapist was an objective consultant to the client. This traditional therapist would also say that it was not their job to change someone. Rather, they were responsible for helping people understand themselves so they could change if they wished. From this perspective, if therapy failed it was the client’s fault. Therapists took money from clients to change them, while declining to take responsibility to change them (1973).

**Changing by staying the same**

Watzlawick raised the question that if we can observe pathological double binds, within families where someone has been labelled as
Schizophrenic, where however a person responds within a relational double bind they lose – is it possible then to create a therapeutic double bind, where however a client responds to our intervention they change (or win) (Watzlawick, 1978; Weeks and L’Abate, 1982)? What if, indeed, it is possible to create a therapeutic double bind?

Trying to facilitate change is immensely difficult when working with someone who is a proverbial walking paradox. What such clients say they want and how they act are often at odds with each other. If what I have described thus far resonates, you will know only too well how hard it is to facilitate someone in altering the patterns of a lifetime even if they desire to change.

**Digital and analogical modes of communication**

Erickson’s analogy of a river as an unstoppable force is comparable to the function of emotion in our lives. He suggested that when we try to block it, we end up not just demonstrating the impossibility of the task but also that the flowing force of the river is much stronger than whatever we might try to block it with (1973). This highlights the immense difficulty of acceptance. How many times do we notice ourselves or others running at the same wall again with our heads and wondering why we are going nowhere fast?

However, if we accept the force of the river and redirect it, the force of the river itself will create a new channel. I find that offering this metaphor to clients like Mary meets no resistance because it is consistent with the non-ordinary logic that she uses to make sense of her problem. Yet if I tried to explain the same idea rationally I might never alter the client’s perception. Mary’s well articulated dilemma is that she understands only too well what she wants to change … but does not feel that she can (Nardone and Portelli, 2005).

**The heart has its reasons that reason knows not of**

When we are trying to effect change in a therapeutic relationship with those who are truly stuck in the contradictions of their lives, it is a useful reminder that *similia similibus curantor* – like cures like (Watzlawick, 1978). If we attempt to use logic and reason to try to dismantle an emotional blockage that has not been constructed through rational means we get stuck in a ‘game without end’, where through its very premise the problem becomes irresolvable. It is not until we
accept the ‘force’ of the problem that we can even consider ‘redirecting’ it. From the moment a client’s perception changes, they inevitably begin to feel, act and then think differently about their problem (Gibson and Boardman, 2016; Nardone and Watzlawick, 2005).

**Therapeutic interventions**

*Speaking analogically or metaphorically; or how if you want to persuade someone, use their own language*

I explained to Mary at the start of the therapeutic process that I had worked with lots of people who she reminds me of and that I needed to highlight carefully how difficult this work is. ‘This work does not tend to reward the lily livered or those faint of heart. This work is the way of the warrior and only tends to reward those who have a great heart for the battle’. You will, I am sure, have noticed that this analogical language, namely that of warfare, resonates with Mary.

I stay within this metaphorical frame throughout our work in order to help Mary to move towards her goal of ‘a more peaceful life, with no fighting’. I resist using linear reasoning and continue tracking the non-ordinary logic which Mary employs in structuring this problem. This emphasis on understanding different logical types is a core component of an ABST model (Gibson and Boardman, 2016; Nardone and Portelli, 2007).

**Dismantling the logic of contradiction that creates paradox**

Due to the contradictions in Mary’s life between what she said she wanted and how she acted, I resisted the urge to instruct her to do anything. I simply asked her to notice all the ways she chooses to make her life even more difficult, not to change anything, only to notice. When framed in this way what request could appear simpler?

However, if you want to reduce something, simply prescribe it. This facilitates a perceptive shift which occurs surrounding the problematic behaviours. These behaviours no longer just happen. Rather, the client has been instructed to observe the behaviours without altering them. When asked to, curiously they find that it invariably becomes increasingly difficult to do so (Gibson and Boardman, 2016; Nardone and Watzlawick, 2005).

When a problem is prescribed it is robbed of its spontaneity, as it is now requested. Prescribing the problem unwittingly introduces a
Trojan horse, which is that you are, of your own volition, choosing to make something worse. Who comes to therapy to receive such strong medicine? Once a client has accepted that indeed they can keep growing their problem, the counterpoint is spontaneously revealed that they can also stop feeding this problem! This reconfigures the client’s perception not through reason but by inducing a feeling that what they thought was helping is actually harming them.

Like the impossibility of explaining an off-colour joke that has just bombed (and believe me I know!), when we prescribe a problem the client finds that they walk into a ‘metaphorical ambush’ where it becomes practically impossible to continue with what has previously felt unstoppable. Perhaps most importantly, the client’s perceptive shift leads to changes in emotion, behaviour and finally cognition.

The simple elegance of this injunction, which focuses on the logic of contradiction to create a paradoxical effect, belies the complexity of its nuanced usage of communication theory. This behavioural prescription of ‘Don’t change only notice’ works on a number of levels. It takes the pressure off a client to have to do anything, which offers some immediate relief but, more importantly, subverts the logic which fuels the problem under scrutiny, because with the pressure removed, the client is now free to resist the problem.

Prescribe in order to reduce, confuse in order to obtain

As our therapeutic work progressed the lens shifted towards inviting Mary to describe all the ways she has chosen to make her life more difficult. She told one story after another of more and more self-inflicted wounds. As she narrated the myriad of ways she had chosen to make life more difficult, I commend her for the diligence she has shown in doing as I asked, in ‘only noticing and not changing’. Additionally, I praise her eye for small detail. I remind her that in order to destroy the enemy we first need to thoroughly know its wily ways.

I listened in session after unrelenting session to what Mary describes as her ‘life as a slow motion car crash’. Little by little she slowly reports that she ‘feels’ different about her problem. Using the logic of contradiction, I suggest to her ‘you may never be strong enough to change the patterns of a lifetime … this is a herculean battle, think David and Goliath’, but I also agree with her logic that continuing with her self-defeating behaviours is exactly how to make her life worse.

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Paradoxically, being invited to talk about how she makes her life more difficult, Mary slowly begins to report instances when she has not been as predictable in ‘running at the wall with her head’. She describes how she is becoming less argumentative and is now letting others get the last word in. She begins to observe increasing exceptions to her own rules about what winning looks like.

This trickle slowly develops into a stream and after a dozen or so sessions the rules start to change as she describes the pain that her life in freefall causes her. One small step leads to another, away from the persistence of the problem. She describes going whole days without fighting with anyone. One day becomes two and so it continues.

Mary finds that for the first time in as long as she can remember, she is getting more practical and commits to cleaning her home, painting several rooms, hiring a skip and spring cleaning. She is not quite as angry with her daughter as she describes a dawning realization: ‘How can I expect my daughter to have a life, if all I do is smoke my brains out, drinking tea, welded to the sofa’. I invite Mary to ease her pain by not talking to her daughter about the changes she wants to make. Instead I invite her to simply focus on showing Susan the changes she is capable of making.

When clinical practice hits a slippery patch and you appear to be aquaplaning

At this point Mary reported benefitting greatly from therapy. We had a strong working alliance and she was able to observe differences in herself which served as the basis of our continuing therapeutic conversations. I then had to reschedule an appointment with Mary in order to attend a close uncle’s funeral and was left a furious message on an answering machine at 2.00am that morning.

When I arrived in work the next day I was greeted with a message: ‘I am sorry I ever bothered going to this fucking place – what a waste of my time, Mary’. Unaccustomed as I am to receiving a message like this, I waited and did not contact Mary. In the meantime I brought the issue to supervision. It was not uncommon for Mary to miss an appointment and wait for a few weeks before phoning me again. We agreed in supervision to wait and see what she chose to do. Mary had previously described how she was able to give other counselling services the run around over the years and that none of them had actually held her to account. I was quite wary of duplicating this redundant pattern.
The dilemma I faced was that I was now on the receiving end of what most of the people in Mary’s life had experienced a form of, namely her irrational behaviour loitering above the self-destruct button. What would make me think that I’m so special, that I as Mary’s psychotherapist might be spared?

Mary phoned me back three weeks later. Her tone was contrite and apologetic as she described going through what she now feels was a break-down. She was in contact with the police and social workers as she tried to manage a very difficult situation with Susan. A measure of Mary’s ‘rationality’ is that, by way of defence, she said ‘if it makes you feel any better, compared to how I treated the Gardai [police], you got off very lightly’. I said that ‘this is a tremendous consolation, I feel so lucky to have only been mildly verbally abused, WOW, what a relief!’ She laughed out loud.

‘Dialogue implies that we begin by presuming the other’s rationality’ (McNamee, 2012). The therapeutic disposition I adopted, unlike McNamee’s presumption, was based on my belief that this problem was construed irrationally not rationally. In staying within this frame, I outlined my dilemma to Mary and said that I had sought supervision on the matter. It is useful to remember that even the most bizarre behaviour is not illogical; it just follows its own logic, that is, a non-ordinary logic (Gibson and Boardman, 2016; Nardone and Portelli, 2007).

Mary was very effusive in articulating all the ways that therapy is helping her to change. I picked up on this and made a suggestion. In fact, it was Mary’s gushing enthusiasm about our work that planted the idea in mind that followed. This ad hoc intervention was inspired by the client and highlights the necessity for a therapeutic lightness of touch to interact in the moment. When the client walks off the pages of our theory, what then? Do we move with the client or cling to our theories?

I suggested to Mary that she promptly writes a letter describing all the ways that she feels therapy has helped her to change and when I receive it in the post, perhaps then I will be able to see clearer how to proceed. I did not have to wait long for the letter. The next day a handwritten letter and a box of chocolates was dropped into reception for me. It read as follows:

*Hi Don,*

*A list of changes that have happened since first attending Hesed House with yourself.*

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1. House is kept in order even on the worst of days when hell is happening. I still keep it in order.
2. Anyone I meet not directly involved with me I have been nice to even when they are rude. I have stopped reacting to the general public.
3. I have stopped thinking that I am going to kill myself. I don’t really think that now. I would not do it. The self harm of banging my head is not severe anymore.
4. I didn’t drink during this crisis, I was afraid to. Normally I would wallow in my own pain.
5. I kept routine going to a point, cancelled appointment if I couldn’t go. But acted normal on phone with different reasons for no show.
6. Know what to do now but need to do it 100% not 80% of time. (But the 20% is still so destructive to my daughter).
7. Can understand how Susan as a teenager sees me now. Need to gain more respect from Susan. I know how to, I just need to do it.
8. Even though ok giving up cigarettes during crisis have started taking anti-anxiety medication 2 days ago.
9. Began being bulimic then stopped after 2 days, controlled eating.
10. When Susan ran off during week another time, I got into car and was crazy driving, after 10 minutes saw how dangerous I was and went home, was aware of danger I was to others and didn’t want to hurt someone.
11. When it all happened and I didn’t have Susan for 12 days, after 2 days I calmed down and got on with things.
12. For the first time I did not push the Gardai too much. Normally when I have been in other crises I get arrested, this time I didn’t. I pulled back just in time.
13. I didn’t stay in negative spiral of negative thoughts. I started thinking of a positive outcome. I’m sick of self fulfilling prophecy.
14. After my first outburst when Susan was gone for 2 weeks, one day I felt that I had been in a car crash and all the hospital staff were helping me for days as I was in so much pain from the accident, then when I was out of danger the Da told me I had caused the accident and had killed a few people. That’s how I felt when I calmed down, ashamed. And taking responsibility.
15. With people staying in my house, if I get annoyed or overreact to something small, I apologise immediately and don’t try to justify it.
16. I’m letting small things go that normally could send me into a rage.
17. I’m beginning to question what I really believe in, why am I so judgmental. I don’t like it anymore.
18. I’m understanding that a lot of people don’t have a perfect life and when I listen to tragedies on radio and I hear the family’s talking I wonder how they can handle it and not go crazy. I see people for the first time who have
to handle real pain and they are graceful. I imagine how would I react? I now see my reaction is too strong which is causing me the pain.

Don, don’t give up now.

Mary

The sea gets deeper the further in you go

In Mary’s letter, her description of a lack of emotional connection with people and the graciousness which others show in managing real problems, is quite stark, extremely painful and yet brutally honest.

A process of change is being described by Mary as she learns to let go of the ‘chaos’ that has engulfed her life. I think her letter testifies to this surrender. She has become curious about how others manage their problems, and feels that she comes up short when she weighs her life against how they handle their cup of woes. Yet she is drawn towards this role-modelling of bearing one’s cross graciously. These second order changes are comparable perhaps to seeds of hope breaking through amidst the former certainty that things will never change.

Mary continues to attend therapy and the changes she reports are happening slowly and incrementally. She now enjoys describing what she is doing well as opposed to its inverse. Our robust, caring, direct and honest therapeutic relationship still serves as the bedrock for this therapeutic alliance. Mary has been quick to acknowledge that she does respect me as she admitted that: ‘no one in my past could put up with me’. In what I experienced from a small dose of ‘the old Mary’, I couldn’t honestly say that I blame them!

Conclusion

In looking backwards we see ahead

As therapists, do we privilege clients gaining insight, awareness or being able to interpret their lives from a new perspective? Perhaps we hope that, following these insights or eureka moments, they will change and that their lives may become less distressed. We can draw from our own clinical experience if we facilitate this type of process. If our clinical focus is on offering new interpretations, narratives, or dialogical discourses, then it could be argued that we have elevated interpretation about interaction as the driver in our psychotherapeutic practice.
If the above broadly describes our practice, then Keeney and Keeney suggest that as therapists, we are primarily serving interpretation, as against what they have called ‘improvisationally inspired inter-action’ (2012). This practice is no slave to any dogma. It religiously adheres to no creed. It allows for each moment, pregnant with possibilities, to give rise to something real, unscripted and inspired that takes risks in the moment to say the unsayable, in order to achieve the unachievable. Imagine, if you will, how musically proficient a lauded improvisational Jazz player has to be to play so loose?

If we assume therapeutic responsibility to facilitate clients to make changes they say they would like to make, then I believe clients will be better served than the therapist holding no responsibility for this process.

Within an ABST model we believe that change in life is constant. We strive to facilitate the conditions in a person’s life where change becomes inevitable. We do this through a number of injunctions including working with the form of logic which the client has used to construct the problem, offering the illusion of alternatives, constraining paradoxes, prescribing the problem and ‘planned chance events’. Within this model we believe that you can only know a problem through its solution. After the problem is resolved then we can interpret how this change transpired.

For the great majority of clients this therapeutic model helps them to make the requisite changes in their lives, even with problems that seem unresolvable and intractable. Sometimes this change occurs catastrophically, other times slowly then explosively and in Mary’s case slowly and incrementally over time.

References


