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Reflecting on the Loss of Empathy for a Parent in Family Therapy Sessions

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ABSTRACT

Reflecting teams play a significant role in family therapy; they broaden perspectives on how family dynamics or problems can be understood. However, what happens when a reflector does not feel compassionate towards a particular family member? There is a risk of biased reflections: families can pick up negative signals, putting the therapeutic relationship at risk. In this paper, I explore how I was supported to explore my lack of compassion for Dad 'John'. It was only after reaching out to an experienced supervisor who undertook an 'internalised other' interview with me – where I played the role of Dad – did my compassion increase. From an ethics of care perspective, I suggest that social professionals need to explore ways to increase empathy and compassion for clients they dislike. If they do not, they are open to valid criticism that they are behaving unethically as professionals. Therefore, there is a need to address deficits in empathy and compassion to sustain ethical social work practices.

KEYWORDS

Reflecting teams in family therapy; ethics of care; dislike of clients; internalised other interviewing

Professional context and practice challenge

I worked at an NHS family therapy clinic in North London in 2022. The clinic specialises in working with families when a family member experiences psychological or other problems. I was part of a reflecting team. Reflecting teams are premised on the idea that family members benefit from hearing a range of perspectives during a family therapy session to broaden their perspectives on how family dynamics or problems can be understood (Andersen 1995). When naming family members, I provide pseudonyms and also alter their identity, age and gender. I developed a strong dislike for Dad 'John', leading to an elimination of compassion or empathy for him over a series of family therapy sessions; his dominant problem-saturated narrative (Morgan 2000) permeated every encounter. John and his wife, Anne, are white, working-class, British, and have two sons aged 13 and 12 years. John developed additional mental health needs in 2019.

As a reflector, I found it very difficult to enter a therapy session without presumptions. Specifically, many of my reflections were partly informed by the pre-session discussion

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(Pote et al. 2001), in which we reviewed systemic hypotheses, presenting issues, family homework tasks and the plan for the session. Phenomenologically, it was difficult for me to 'bracket' my attention to experience the Maloney family and their interactions in the 'here and now' of a session as my perception of Dad John, for example, was informed by previous interpretations of our encounters (e.g. berating and shouting at his children in previous sessions; his children's stories about his behaviour outside sessions; the younger son crying in every session–he loved his Dad but was finding it difficult to give him the attention in the way his Dad demanded).

Over time, a sense of compassion for John collapsed. I do not believe that my reaction to John can be explained by his significant mental health needs. I have worked with other Dads with similar mental health issues where I was able to remain compassionate. Rather, I disliked John, as he demanded persistent reassurance and attention from his children and caused them to become upset and withdrawn during sessions. I had a physical reaction to his presence in one session by breathing rapidly and feeling a low moan in my throat. I mentioned my reaction and dislike for John in one of the post-therapy session reviews, but I did not have time to process my feelings. Insufficient time and space to reflect on feelings and thoughts is dangerous for practice (Ruiz-Fernández et al. 2021). If compassion weakens, the risk of biased reflections (Kelly 2022) increases. Specific family members are likely to receive negative signals from reflectors, leading to an unravelling of the therapeutic relationship between the team and family.

Ethical dilemma

I judged Dad's actions towards his children as wrong, and this judgement reduced my compassion towards him. From a deontological or utilitarian viewpoint (Honderich 2005), my professional judgement can be considered morally understandable. If we consider child development theories as a guide for framing parenting principles, John's parenting approach could be considered morally wrong, as it is difficult to perceive an expression of care in his actions. From a utilitarian perspective, it could be argued that John's behaviour generated distress for other family members. In other words, other potential actions by him as a parent could increase the level of happiness in his family.

However, while Dad's actions could be deemed morally suspect from a consequentialist or deontologist perspective, my actions as a reflector could also be deemed morally questionable from an ethics of care perspective (Gilligan 2014). Specifically, by drawing on traditional moral frameworks to judge John's actions and their consequences for his children, I eliminated my empathy and compassion for John, but without placing a moral obligation on me to consider the consequences of my own judgement for John and his family. If I had adopted an ethics of care approach, I would have drawn on a normative ethical theory that invites social professionals to reflect on the choices of their behaviours, particularly in terms of the consequences for vulnerable individuals such as John. Gilligan (1987) invites social professionals to not only consider what is fair in terms of assessing service users' behaviour, she also invites us to reflect on how we should respond to situations where we experience a loss of empathy and compassion for them.

Steps to regain empathy and compassion

Family therapy offers several tools for reflectors to regain empathy and compassion for clients, one of which is self-reflexivity. While Burnham (2005) offers a definition of self--reflexivity, I understand the term as an invitation to remain open to the possibility that my thoughts, feelings, and judgements towards family members in a therapy session are somewhat informed by my interpretation – perhaps unconsciously–of my previous life experiences. If I remain open to why I might respond in certain ways during a therapy session because of these interpretations, this gives me a choice on how I can proceed as a reflector during a session. I reflected that John might constitute a 'trigger' family (McGoldrick 1982) for me in that he possibly touched on some vision about how I expect Dads not to behave. Indeed, when I was a child, I had a distant relationship with my own dad, but I do not think my relationship with him could fully account for my visceral reaction to John's interactions with his wife and children.

Additionally, family therapy invites reflectors to consider social graces. Rivett and Buchmüller (2018) suggest that graces are a way to explore experiences and their meanings intersectionally. Therefore, while I reflected on my and John's experiences and understanding of issues such as class, mental health, gender and parenting, I still struggled to shift my lack of empathy toward John. Consequently, my strong negative reaction to dad's behaviour towards his children required further exploration, beyond social graces and self-reflexivity, if I were to be of any use to this family as a reflecting team member.

I brought this dilemma to my supervision group, and the group facilitator conducted an internalised other interview (Tomm, Hoyt, and Madigan 1988). The exercise transformed my view of Dad, increased my compassion and empathy for him, and led me to reflect on the significance of professional discourses (Foucault 1998) in generating moral stances (Fredman 2004) towards families. It demonstrated the benefit of group supervision for reflectors to increase their own systemic self-awareness as relational beings (Rivett and Buchmüller 2018), a key element of relational ethics (Noddings 2013).

Through a series of questions, I was guided to imagine myself as John when he was a young person, to think about his hopes and dreams, and to think about how anger appeared in his life before and after he became unwell. As a result of this exercise, I understood John's anger as an expression of him wanting to remain visible and active in his children's life. By not displaying this anger, John was afraid he would become invisible. Consequently, I saw John's demonstration of anger as representing a positive meaning for him while creating negative consequences for his children.

The internalised other interview encouraged me to generate 'narrative multiplicity' (Penn and Frankfurt 1996) in that I interpreted John's voice to mean different things: first, it was a cry for help, recognition and visibility; second, it was also an instrument of emotional maltreatment towards his children. The internalised other interviewing activity also enabled me to synthesise my psychodynamic response (Winnicott 1949) (i.e. negative countertransference towards John and his behaviour) with a new systemic interpretation of his behaviour (e.g. John's loudness and hectoring symbolise John's desire to remain visible and relevant to John's children) to increase my empathy as a

reflector towards John. There was very little in the empathy tank for John before I undertook the internalised other interviewing exercise. After the exercise, my compassion and empathy increased for John, important elements for a social professional to demonstrate in a therapeutic relationship.

Ethical reflections and implications of struggling with a lack of empathy

My primary professional discipline, social work, might be a factor in how I reacted to John's behaviour. Social workers, because of their professional formation, are immersed in discursive practices (Foucault 1998) which require them to make professional and moral judgements about parenting capacity. Reflecting back on my strong reaction to John's behaviour, what now comes to mind is Fredman's (2004) contention that feelings constitute an expression of a person's moral stance and relational position to the other. As I had feelings of anger, fear and dislike for John, it is worth considering whether my moral stance was informed by ethical theories underpinning social work training and practice. Social work is a profession in which decisions are made about a client's actions in terms of rightness and wrongness (e.g. morally wrong to abuse your children), very much sympathetic to deontological or utilitarian normative stances.

As the role of a systemic therapist is somewhat different from that of a social worker, we can speculate that there is also a difference in the ethical theories underpinning social work and family therapy. Professions such as family therapy may place a greater emphasis on an ethics of care approach (Noddings 2013; Gilligan 2014), creating time and space for more trusting and honest interactions to emerge, where people feel more accepted. For example, social workers may prioritise making judgements about the suitability of family members to provide care; in contrast, family therapists may be more focused on identifying and healing family interactive patterns. Therefore, while the roles of practitioners in both professions overlap at times, a difference in roles also implies that each profession is likely to draw on and prioritise a particular ethical framework to inform situated practices. In a more abstract and universal sense, both professions may identify with similar ethical theories. However, within a specific practice context, each profession may prioritise a particular ethical framework to justify its actions.

For example, if I was working as a social worker and witnessed Dad's behaviour, I may have explored taking actions to reduce the effects of his emotional outbursts towards his sons. This was not my role as a reflecting team member, and I had an opportunity through a supervision group to explore my empathy deficit which undermined my relationship with Dad. Without attending to the nature of this relationship, Noddings (2013) might argue that I was relating unethically, and I was therefore obliged to attend to my thoughts and feelings towards John. If I avoided an examination of my loss of empathy and compassion, I would have behaved unethically from an ethics of care perspective (Gilligan 2014). While I did not explicitly consider Tronto's (2020) work at the time, I drew implicitly on at least two of her ethical qualities of care to rediscover empathy and compassion and adopt a more relational approach to Dad.

First, Tronto (2020), within the context of tolerating dislocation (Raghuram 2016), suggested that to provide care and support, the self must learn to become competent in

doing so. It was a necessary condition to recognise that John needed support, but this recognition alone was insufficient in terms of me behaving morally as a reflector towards John and his family. With the support of an external supervisor, I would have remained incompetent in meeting John's needs because of the absence of empathy and compassion for him. With help, I was able to creatively imagine why John was acting as he was towards his children. Therefore, through the support of another professional, I developed a disposition to become more adept at meeting John's and his family's needs.

Second, Tronto (2020) suggests that attentiveness to context is an important component of the ethics of care approach. While she primarily focuses on the need to attend to the needs of others, I would argue that part of this context also relates to social professionals having to pay attention to their own needs and seek support, especially if they experience an empathy deficit towards a client. For me, attentiveness aligns with virtues of accuracy and sincerity (Fricker 2007) in that practitioners not only need to have competence to work with clients, they also need to cultivate the ethical disposition to do so in authentic ways.

Recently, I have also become intrigued by Burnham and Nolte's (2019) invitation to trainee clinical psychologists to recognise and integrate different aspects of their social identities to create a more fulfilling and authentic relationship with clients. I think this is a noble aspiration, and a similar invitation can be made to other social professionals. However, for such an aspiration to be realised, it might require practitioners to remain alert to contrasting and possibly contradictory normative frameworks, which at times might be difficult to reconcile. For example, a social work student might hold firm beliefs about macro- or meso-level explanations of injustice in society that place additional pressure on families, but at the same time, the role of a statutory social worker is to work at a micro-level to assess and manage risk to children within the family, without having the work capacity to challenge wider societal injustices. Arguably, without spending time examining these limitations and their implications, social professionals and service users will suffer a form of epistemic injustice (Fricker 2007).

Finally, one implication of my experience is that professionals working in health and allied social care professions may need to explore the extent to which different professions converge or diverge on normative frameworks for practice. It was only through having a difficult practice experience that I started to consider the extent to which social work and family therapy differ in their ethical stances towards service users and the understanding of problems. This begs the question of whether either profession can incorporate some of the ethical viewpoints of the other.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Notes on contributor

Mark Taylor is a registered social worker. He teaches and researches social work at Goldsmiths, University of London. In recent years, he has developed an interest in systems thinking and family therapy. This paper is informed by his recent experience as a member of a reflecting team in a family therapy clinic.

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