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Family Therapy, Personal Life and Therapeutic Practice

The Map of Relational Resonance as a Language for Analyzing Psychotherapeutic Processes

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Abstract

In this article a middle range theory, called "the map of relational resonance," will be presented. The concept of "relational resonance" as defined is developed for understanding the different ways in which therapists' own values and personal and private experiences create a context for their therapeutic work. The map of relational resonance offers both a constructive and a critical perspective for family therapy practice. We suggest that the map of relational resonance could be an important aspect of family therapy education and training. In understanding and conducting family therapy and systemic practice the map of relational resonance is a helpful framework for discussing systemic therapeutic practices and has the potential to be developed as an evaluation tool.

Keywords: Grounded Theory; power; personal and private life; resonance; therapeutic practice.

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Introduction

Psychotherapy process research emphasizes the importance of the therapeutic relationship as both a starting point for a successful therapeutic process and as the vehicle for change (Høglend 1999; Wampold, 2001; Norcross 2010). However, when it comes to the ways in which family therapists' personal and private experiences influence their clinical practice and their relationship with their clients it is difficult to find relevant research. The same seems to be the case when we look into psychotherapy research in general. There seems to be a gap when it comes to understanding how psychotherapy is influenced by the therapist's personal and private experiences and how they become involved in creating a therapeutic alliance (Jensen 2007; Jensen 2008).

Research into the relationships between therapists' personal experiences and their therapeutic practice is described, leading to a mid-range theory called the map of relational resonances. The map of relational resonance will be used to widen the understanding for family therapy practice.

First in this article "the map of relational resonance" will be presented. Second some examples from the analysis of the research will follow. The map of relational resonance is based on a doctorate in systemic psychotherapy (Jensen 2008). The map of relational resonance offers understanding of the different ways in which therapists' own values and personal and private experiences create a context for their therapeutic work and the development and maintenance of therapeutic relationships. The map is based on the relationships between some Grounded Theory (GT) categories that emerged in the research through a data analysis of interviews and videos with family therapists. The examples come from this research.

The map of relational resonance offers a language for analyzing psychotherapeutic processes and carries potential as an evaluation tool both in family therapy education, and in evaluating clinical practice in general. The concepts that are developed in this article are based on an understanding of the possible interactions between the therapist and the family or client, as different types of *relational resonance*. Discussion of key findings from psychotherapy research concerning the relation between the therapist and the clients will provide a context for the map of relational resonance.

Method

The research focused on understanding how family therapists make meaning of their private and personal experiences, such as their own divorce, mental health problems, addiction and other experiences from their own life, and how this impacts on their therapeutic relationships. Theory gains meaning by being grounded in "…good, powerful, convincing examples." This is the basis for grounded theory (Dallos and Vetere, 2005, p. 53) and this is the aim of the research. In Grounded Theory research, context is thought to be rooted in the phenomena that are being studied, and therefore an individual or therapist's process of meaning-making cannot be understood outside of the personal and professional context in which it occurs (Ward, 2005).

Participants

The participants consist of seven professionals with family therapy training: two clinical psychologists, three nurses, and two social workers. There are two men and five women. When they were interviewed and video taped, they worked in adult psychiatry, in child- and adolescent psychiatry, Family Counselling Offices and in private practice.

Design

The primary purpose of this research was to explore in depth, with seven participating systemic therapists, the patterns that connect their own personal experiences and lives with their clinical family therapy practices. Theoretical sampling helped in selecting each participant, based on Grounded Theory analysis (Charmaz 2006) of the previous participant's material, and the constant comparison with each previous case. This was part of preparing for the semi-structured interview questions that were asked of each new participant. All analysis was within a Grounded Theory design.

Two interviews were conducted with each of the first four therapists, punctuated by watching a video of a first family therapy session. The second interview provided an opportunity to present the analysis of possible links between the first interview and the video and provided a validity strategy or "member check" for the first interview and its subsequent GT analysis. The final three therapists were interviewed once only. This helped establish the GT process of data saturation. When the research was done, all participants were invited to comment on how their videos and interviews were used.

I also used interpretative theme analyses that are connected to the aim to "understand and represent the participants' point of view" (Dallos and Vetere, 2005, p. 53). I assume that these points of view are relatively stable over time and I want to know which kind of

processes alter these points of view and what happens when they change. In this research, I also use Theme Analysis (Luborsky 1994). The videos were analysed using Theme Analysis (Dallos and Vetere 2005).

The research data

The research material consisted of transcribed semi-structured interviews with seven systemic family therapists, their genograms, e-mail reflections from the therapists after interviews, and videos of the therapists' first therapy sessions with clients. All informants were invited to send me their reflections after each interview. I also invited them to give some comments on their current views on how they see the relations between their personal life and their clinical practice.

With the help of videotaped therapy sessions, observation as method was brought in to be a part of my material. After coding and analyzing first the transcript and then the video, the results were compared and contrasted in looking for patterns and narratives that could be connected. When connections between transcript and video were constructed, the construction was brought back to the participant in the next interview. In this interview my constructed relation between a story in the first interview and the video were presented. This new interview also worked as a validation procedure. The process can be illustrated with this model:

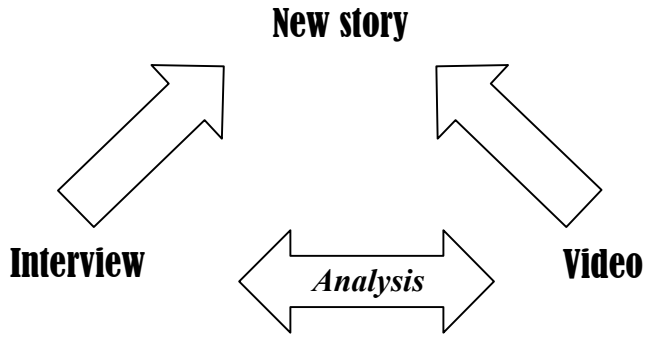

Fig. 1: The sampling process

In all four interviews, we (the informants and me) found important and meaningful links between the videotaped therapy session and stories told during my first interview with them. All seven informants in this research project were able to identify meaningful connections between their personal and private lives and their therapeutic practice.

Power and context

Psychotherapy in general and family therapy in particular may be viewed as a practice of power and should be viewed in this way to some extent. When it comes to topics such as gender (Burck and Daniel, 1995), ethnic minority situations (Hildebrand, 1998; Cross and Papadopoulos, 2001) and professional culture (White and Epston, 1990; Ekeland, 2001) the need to analyse power relations seems to be as pressing today as it was earlier.

In constructing the map of relational resonance, I have used the concept of power in a particular way, to understand the influence on clients of the family therapist's personal and private values and culture. The concept of power emerged in this research in the data analysis through the narratives some therapists told of how they used personal and private experiences direct or indirect in their clinical work (see "Examples of therapeutic colonization" later in this article). The concept of the psychotherapy relationship as a type of power relationship is not mentioned in many handbooks and textbooks in psychotherapy. Some of the handbooks (Lambert, (2004): *Handbook of Psychotherapy and Behavior Change*; Hubble, Duncan, Miller, (eds) (1999): *The Heart & Soul of Change: What Works in Therapy*; and Hougaard, (2004): *Psykoterapi – teori og forskning*) do not mention power and power relations in their comprehensive documentation of psychotherapy research.

Foucault claims that power is relational and appears in all kinds of relations. Foucault claims that power gains momentum as more people come to accept the particular views associated with a belief system as common knowledge. Belief systems define their authority figures, such as priests in a church or medical doctors. Within such a belief system ideas seem to deal with what is *right* and what is *wrong*, and similarly, with what is *normal* and what is *deviant* (Schaanning, 1993).

Resonance

In the research, I chose to explore how the therapists' personal and private context adds meaning to their therapeutic practice. My starting point is Bateson's (1979) idea that context is our mental or psychological frame of understanding of our own life and experience. The context that is of interest here is when resonance between the therapists' personal and private life and therapeutic practice forms a meaningful whole in the therapeutic process.

Money Elkaïm introduced the concept of resonance to help us understand the dynamics between how one part of life may influence another. He says: "Resonance occurs when the same rule or feeling appears to be present in different but related systems" (Elkaïm, 1997, p. xxvii). What occurs then is a kind of symmetry that invites the person to relate in

certain or similar ways to what is going on. *Resonance* is a concept for giving meaning to the circularity that occurs between the therapists' personal and private lives and clients' narratives. When Elkaïm mentions "the same rule or feeling" it is possible to think that rules are articulated or possible to articulate and that feelings are unarticulated and can be brought into conscious awareness or as a part of analogue communication. Feelings may of course be articulated, but the articulation is not the feeling, in the same way that the map is not the territory.

Martha Rogers broadens our understanding of resonance by presenting it in a relational perspective. She says that resonance with the environment sometimes may be "harmonic, sometimes cacophonous, sometimes dissonant …" (Rogers, 1970, p. 219).

Relational resonance

The concept of resonance is developed to include both personal resonance and relational resonance. This means that resonance both takes place within a therapist's mind and emotions (personal resonance), and in the individual family members' minds, and at the same time, between the therapist and the family or client. In this article we will concentrate on relational resonance.

The concept of resonance is developed to understand what occurs when a client or a family communicates and presents narratives that evokes and/or activate the therapist of her or his own personal and private experiences. This awareness is not only intellectual and possibly outside conscious awareness, but also embodied as well. The two aspects we are studying here are the resonances between a family therapist's personal and private life and her or his professional life. The emphasis on resonance will be developed to include several related concepts that add new meaning to the findings from this research project.

The therapeutic relationship is one of the factors that promote change in psychotherapy. How this element in the therapeutic process adds meaning to clinical practice is important to understand (Wampold, 2001; Skovholt and Jennings, 2004; Lambert, 2004; Orlinsky and Rønnestad, 2005). In this perspective, the influence of the therapist's personal and private experience on the therapeutic process is one important factor to take into account and understand. Skovholt and Jennings' claim in their research that master therapists describe their awareness of their "selves" as "… an agent of change in the relationship" (Sullivan et al., 2004, p. 63).

The map of relational resonance

The categories in the map of relational resonance emerged from Grounded Theory analysis of the transcribed interviews. The analyzing process was done manually by finding themes in the material that were sorted into categories. On the basis of the emerged categories a mid-range theory was developed. The map of resonance is meant to add reflections to the understanding of what is going on **in the therapy room** when it comes to how the interactional processes are influenced by the therapists' personal and private experiences. It is meant to be an aid to supervision and training. An overview of the structure and the concepts used in the map is presented below:

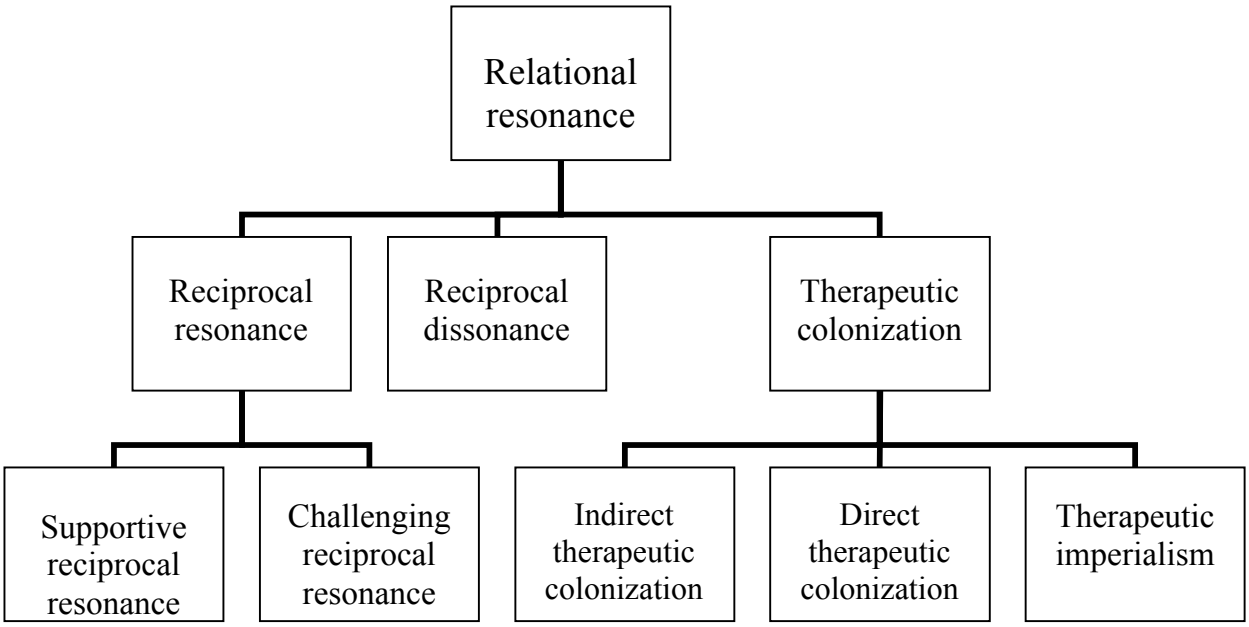

Fig.2: The map of relational resonances.

This relational map of resonances is developed to explore and explain how systemic family therapists in this research project influence their families and clients within the framework of their own personal and private backgrounds.

Reciprocal resonance

Reciprocal resonance covers a therapeutic process where the relationship between the therapist and their clients has the character of mutual understanding. "Indeed, of the multitude of factors that account for success in psychotherapy, clinicians of different orientations converge on this point: The therapeutic relationship is the cornerstone," (Norcross, 2010, p. 114). Reciprocal resonances cover therapeutic meetings where the client's history or situation recalls memories and emotions by the therapist that connect the therapist and the clients to common references. This connection might be fully articulated, partly articulated, or

unarticulated. Reciprocal resonances may be punctuated as more or less supportive and more or less challenging both by therapists and clients.

Reciprocal resonance might occur in relations that can be described as both symmetrical and complementary. Basically, the relation between a family therapist and a client will be described as a complementary relation. The client asks for help or support and the therapist will offer help or support. However, a therapeutic relationship might also take the form of a symmetrical relation in sequences or parts of the process. For example, a client or a member of a family in therapy might enter into a fight or a competition with the therapist to represent the best or the right understanding of a problem and the therapist may seek to get into an expert position to gain respect or show competence.

Supportive reciprocal resonance

Supportive reciprocal resonance may be viewed as the secure base of therapy (Dallos and Vetere, 2009) and as part of joining in family therapy (Minuchin, 1977; Jensen, 2009). However, supportive reciprocal resonance is meant to cover a more specific and narrow part of a therapy session or a therapeutic encounter. Supportive reciprocal resonance describes the elements in joining that stem from the therapist's personal and private life and that are brought into therapy by the therapist's interaction with clients. Supportive reciprocal resonance forms the frame for a sequence or sequences in therapy, in which resonance from the client's stories, manners, behaviours, culture and background add meaning to the therapist in a way that comes to affect the relation between the therapist and the client(s) and give the therapy a new direction based on this supportive resonance.

Challenging reciprocal resonance

Challenging reciprocal resonance forms the frame for a sequence or sequences in therapy, where the resonance from the client's stories, manners, behaviours or culture and background challenge the therapist in a way that comes to affect the relation between the therapist and the client(s) and gives the therapy a new direction based on this challenging resonance. This may limit or endanger the therapeutic relationship, but it may also offer some new directions for the therapy.

Reciprocal dissonance

Cognitive dissonance is a theory from social psychology. Festinger (1957) points out that cognitive dissonance represents lack of accord between values, attitudes, ideas,

understandings, and experiences in a person's life. In our lives, we strive for dissonance reduction (Saugstad, 2007).

Reciprocal dissonance occurs when clients awaken feelings and behaviour in the therapist that she or he finds unpleasant and that hinder her or his curiosity and empathy and drives the therapist to reduce or end the therapeutic relationship. This might also be the other way around. If the therapy ends here, both the therapist and the client(s) will probably end up in an unfruitful therapeutic process. Cases like this should be brought to supervision and/or the client(s) should, if possible, get a new therapist.

Some clients act and behave in a manner that some therapists find hard to manage**.** Two typical topics that trigger some therapists emotionally are clients that tell the same story over and over again or repeat the same theme over and over again. Another topic is complaining, including those clients who complain without appearing to make any move to change.

Therapeutic colonization

Therapeutic colonization is one special form of resonance. Colonization is best known as a political concept used as a framework to understand what goes on between powerful nations and their relations with developing countries. Jürgen Habermas built on the ideas of Talcott Parsons in his use of the term 'colonization' when he speaks about "colonization of the lifeworld" (Schaanning, 1993). Lifeworld is what Habermas call "...the "background" environment of competences, practices, and attitudes representable in terms of one's cognitive horizon" (http://en.wiki-pedia.org/wiki/Lifeworld). In linguistics, the concepts "linguistic colonization" and "linguistic imperialism" were coined to develop an understanding of how language constructs and constrains our worldview (Vedeler, 2007).

The concept *therapeutic colonization* describes how a systemic family therapist's personal culture, experience, and moral values in different ways influence her or his therapeutic practice. This represents difficult and problematic forms of practices. Therapeutic colonization represents the creation of a context that reduces the sphere in which reciprocal communication operates. The reduced sphere for reciprocal communication is based on the therapist's use of her or his power to define and introduce topics for conversation. This use of the therapist's power to form and frame the conversation makes it necessary to bring in discussions of ethical accountability into the understanding of systemic family therapy. At the same time theory can be a basis for being held accountable for our ideas, and supervision and personal therapy help us identify and understand our prejudices.

Indirect therapeutic colonization

Indirect therapeutic colonization occurs when the therapist's own personal and private experience influences systemic family therapy in an unplanned and unarticulated way. The therapist is not always aware of what is going on, and this may create a context that could be understood to be outside what the therapist claims as her or his professional practice. The specifics of their power relationship might be hidden both for the therapist and the client.

Direct therapeutic colonization

When direct therapeutic colonization occurs it is the therapist that uses her or his power to define the topics for discussion despite what the clients ask for or introduce as their concerns or needs. The therapist defines the topics based on her or his experiences from own personal and private life. In this way the sphere in which reciprocal communication operates is reduced. A power relationship is thus developed.

Therapeutic imperialism

The concept of imperialism is a political one coined in the late 1500's to reflect and give a name to the politics of expansion from Europe into Africa and America. The concept is integral to different political theories and is used to give an understanding of how power may be used to oppress a state, culture or a people. Imperialism is usually defined as a term applied to a state that tries by force to conquer and shape other societies to conformity with its own ideas or values. In addition, if we look at the concept from an etymological point of view, we find that "imperial" stands for "order" or "command." Therefore, the concept is most appropriate in describing a relationship where the distribution of power is unevenly divided and where one part uses power to support his or her concerns.

I will define "therapeutic imperialism" as a situation or a sequence in therapy where the therapists ***using direct power*** articulate a personal value base or personal experiences from their private life, which forms the direct background for clinical interventions, against the will of one or more members of the family in therapy. The use of power and going ***against the clients' explicit will*** makes the difference between therapeutic colonialism and therapeutic imperialism.

Ethical considerations are important when reports about therapeutic imperialism are received from therapeutic practice in the creation of ethical accountability. Family therapists are meant to respect and support clients' own values and culture as a point of departure for therapy. When ethical standards collide or conflict inside a family or between the family and therapists, the therapists need to carefully take up and discuss these types of conflicts and

problems also from an ethical and legal point of view. In these situations, applications of the therapists' power are obvious and kept as visible as possible for all involved e.g. in child protection work.

In this research the therapists' own ideas about what governs their therapeutic practice were often a main source of understanding of what was going on in a therapy session. These professional ideas may, however, from time to time be overruled by other aspects than those considered to belong to professional practice. When a therapist claims that she or he is governed by her or his professional background and experience, he or she is claiming that theory, research, ethical and other professional considerations form the *context* for her or his therapeutic work.

In the following section two main categories will be used to illustrate how the map of relational resonance has grown from empirical examples. The two categories that are used are reciprocal resonance and therapeutic canonicalization.

Examples of reciprocal resonance from the GT analysis

One experienced therapist worked with a family with a young girl that wet herself at the age of twelve. The therapist was not able to communicate with the girl during the family therapy sessions. In the third session she decided to tell a personal story. She addressed the young girl and said: "*When I was twelve years old, I wet myself too."* For the first time the girl looked at her and they could start talking.

Another examples is one research participant that says it from time to time has been profitable to be familiar with the pietistic religious working milieu that has formed part of his own background. It helps him understand some of his clients. In the same way, another informants' role as an intermediary in his own family from early life on has formed some of his ways of entering into conversations in the therapy room. He says that the influence from his family is connected to his role as *"... an intermediary or mediator... between us children and the grownups."* When he was a teenager he was a go-between for his parents and between his parents and grandparents and other relatives. He thinks this has formed him as a "helper." When I ask him how he experienced this role as a teenager he emphasised that he liked it and that it was exciting. It gave him a particular and special position in the family as a whole.

This kind of reciprocal resonance is based on common experiences within the culture of the therapists and clients. One informant's narrative about the importance of being heard can illustrate how reciprocal resonance can be established and be a part of a systemic family

therapist's clinical practice. She has herself been in couple's therapy, and this has been a very important experience in her life. She was heard and deeply understood by the therapist and that came to be a central value for her in her own clinical practice. When I asked her in which way it was important for her to be heard, she said:

> *"Yes, and that is…a guideline for me now, that people shall be heard. That even the damned shall be heard. And now and then there even comes one in who wants to blame another for something…So that voice is just as important, both, all voices are just as important. …it was actually that simple change there which led to my actually coming out of that. And afterwards I went into a long therapy process in order to "hang up" and all that."*

The experience from her personal therapies initiated by crises in her own marriage has formed a part of her own clinical practice. All clients shall be heard and she denotes that as a guideline for her own practice. She sometimes tells clients that she has used therapy to get help in solving her own difficult problems connected to breaking up from relationships.

Although another informant had supported the idea of "the not knowing position" (Anderson and Goolishian, 1992) for many years, it was only after being in therapy himself that his role as an expert was challenged. Being a client himself added some new dimensions to his understanding of therapeutic practice, such as feeling emotionally trapped in the therapy room although he knew in principle he could walk away.

One of the informant's stories is an example of reciprocal resonance. Challenging reciprocal resonance occurred when she met with a woman frustrated because of her sick husband. The woman was healthy and would be living with this sick man for a long time. This story gave resonance to some of the therapist's experiences with her own sick and dying husband. She said that she recognised aspects of her own experience in the woman's stories. She thought it was a mistake for her to go on without commenting on her own parallel situation. She said to this client: *"... I have been through similar things in my life. And it affects me and it makes it so that I think that you should go to another therapist."* The woman chose to go to another therapist and my informant had to take sick leave not long after this because of her sorrow.

Another example of reciprocal resonance is another informant's link between her experiences as a young woman in a religious charismatic group and her view of these groups today. She says that she is one of the few *"…that dare to say that I wish that* (The charismatic group) *would be taken away from patients*". She does not refer to any professional explanations or research to give reasons for her opinion, but to her own personal experience

with being a member of such a group. However, in general it is somewhat dangerous and unethical to use one's own personal experience as the *only* reason for this kind of advice. This could lead to what I call "therapeutic colonialism" or "therapeutic imperialism."

Examples of therapeutic colonization from the GT analysis

One example of therapeutic colonization occurs when the therapist is not aware of relational resonance. An informant, a family therapist with more than 30 year of experience, at one point in the videotaped therapy session asks the couple if they had talked about the problems in their marriage to anyone else. In the first interview with him he emphasised why he avoided giving advice based on his own personal and private experiences. So I was surprised when in the video he asks the couple what they feel about telling their parents, siblings, and friends about their situation. He says the following to the couple:

> *"One could say of course to parents and acquaintances, to family and friends that one is going to family counselling, so that they will understand that this isn't something one has done with a light heart, for example."*

At first, I did not understand his reasoning for giving this near-advice to the couple. But then I remembered from his first interview with me, one of his own private stories from his time as a young student. His girlfriend became pregnant and he decided not to marry her. She would keep the child and that meant that he would be a father. That also meant that his father and mother would be grandparents and his siblings would be uncles and aunts. He knew he had to go home to his pietistic parents and the rest of the family and explain that there would be a new member of the family and that he would not marry the child's mother. In the late 1960's this was a difficult message to give in a Christian, pietistic environment in eastern Norway. They "had to" include a new member in the family born outside marriage, a happening viewed as terrible in many families. However, his family included the child as one of their own. They managed to be real grandparents to the child. In his home *"... it was possible to have an open dialogue about most topics"* he says.

In my second research interview with him, I decided to link this good, early experience from his private life to his intervention when he had "advised" the couple to go home and tell their parents. When I met him for the second interview I was prepared for him to reject this interpretation or to ignore it, or even that he might be angry with me for trying to suggest he acted against his own professional principals. I presented my idea about this connection for him and said:

> *"You said that you thought it might have been an idea for them to tell their family and maybe their friends. And then I thought that that was something you also did when something dramatic happened to you and in your family. The first thing you did was to go home to your mother and father…, to say that there is actually a grandchild on the way."*

When he heard this, he was stunned and obviously moved, with tears in his eyes, and he remarked: *"I can feel that I'm moved."* When I point out to him that he is close to advising the couple to tell their parents and siblings about their problems, he confirms that to him these kinds of stories represent an important part of his value base in his understanding of being a family. At the same time, he is surprised that he really said what he said or gave that advice. To do this, is contrary to his ideas about how therapy should be done.

These examples have shown that therapeutic colonization may occur even in the practice of a very experienced therapist. When in a sequence the highest context seems to be the therapist's personal and private value base, a sequence of the therapy session may be formatted by these values. These examples may give a rationale for regular direct supervision, not only as part of family therapy training programmes, but also for qualified therapists.

One informant shows one example of therapeutic colonization in the video of a first therapy session. The couple she meets make a relatively clear and distinct request for help. The woman opens by saying that they had decided to divorce but as they have two children they need help to communicate. Although the therapist asks about the family as a whole and all their severe problems, the husband's alcohol abuse is only one among all these problems. However, after these opening questions and answers, the therapist uses almost the whole session to talk about the husband's alcohol abuse.

When I came back to this therapist for the next research interview, she said she felt trapped in the session and that she thinks her own husband drinks too much. She said: *"...It isn't more than one or two years ago that I sat in a Family Consultation Office and said 'I'm leaving if this doesn't get sorted out."* Although she was aware of this parallel when she conducted the session she did not manage to come out of it or give the therapy session the direction the couple asked for. Her repeated punctuation of the husband's alcohol abuse reduces her ability to listen to their needs and what they came for.

This example illustrates how a personal and private situation may form and organise a therapy session so that therapeutic colonization can take place. This illustrates how a therapist may lose her curiosity and openness and let her own private situation govern the therapy session. However, once these processes are articulated they are open for supervision, self-

reflection, and for adaptation. Indirect therapeutic colonization, on the other hand, is often unavailable or difficult to discover unless observation is a part of the way of working.

A clearer example of colonialism occurred when one informant and her colleague intervened in a family where the father refused to let his new children know that he had two children from a former marriage. Based on her own experience from her parallel experience as a child, she stated that it was wrong to keep this kind of secret from children, and against the father's will. They decided to tell his new children that they had two half-siblings against the fathers will. She worked as a co-therapist in a family unit when she worked with this family. This probably means that a majority of her fellow family therapists supported the intervention. However, I question seriously whether personal and private experiences and values are a sufficient foundation for clinical interventions like this. Stories like this bring up the need for discussions of family therapy practice in an ethical framework and the need for ethical guidelines.

All informants claim that their personal and private experience has been meaningful and supportive in their therapeutic practice. In a general way, the interest in talking and listening to people may be seen as an important kind of supportive reciprocal resonance that forms the starting point for a therapy session. Perhaps this is the most basic starting point of them all for a systemic family therapist. If so, this should have implications for training.

One main finding in this research project is that six of the seven therapist participant informants could tell important stories of how their personal and private experiences in life have influenced their therapeutic practice. The one informant who did not tell stories that linked his personal and private life to his therapeutic practice was open to look for such links and found such links logical and possible.

Discussion

Although the research documented in this project has limitations when it comes to selections of participants, number of participants and hours of therapy sessions studied, the project shows important links between the therapist's private and personal life and their clinical practice. The research also shows that these links both might be viewed as a benefit for practice and as problematic for practice.

It is a lack of research in this area of psychotherapy research that means we need to do much more work when it comes to understand how family therapy is influenced by the therapists own personal and private experiences form own life (Jensen 2008).

When we need to reflect upon the links between private life and professional practice, should we be asking for therapy, consultation, or supervision, (Jones 2003)? This question is often supported by the idea of a strict division between what is private and what is professional. Today, this division between professional and private seems to confuse our understanding of psychotherapy. A more fruitful position could be to look for "...how to achieve an appropriate balance between the 'private' and 'professional'?" (Roberts, 2005; Graff, Lund-Jacobson and Wermer, 2003; Protinsky and Coward, 2001; Hurst, 2001).

Therapeutic ideas are not outside culture and society. We are all subject to similar social discourses. Therapeutic ideas are a part of culture and come forward in a culture. For example, the idea of the "self" is of another kind and much weaker in some eastern cultures. In his book "Rewriting the self. History, Memory, Narrative," Mark Freeman claims that "...a life history, rather than being a 'natural' way of accounting for self, is one that is thoroughly enmeshed within a specific and unique form of discourse and understanding" (Freeman 1993, p. 28 in Johansson 2005, p. 230). Personal stories like biography or personal narratives are nothing natural or universal but they are culturally constructed. Diverse social constructions of the self, faith and religion, and other cultural differences are among the issues that make it necessary to develop the map of resonance as a tool in family therapy education and supervision.

When Orlinsky and Rønnestad carried out their comprehensive research on how psychotherapists develop, 3 in 10 of the Western therapists actually were in personal therapy when they participated in the study. They also found that "Clinicians with no experience of personal therapy showed the lowest rate of felt progress and the highest rates of regress and stasis. By contrast, practitioners who were currently in therapy showed the highest rate of progress and the lowest rate of stasis" (Orlinsky and Rønnestad, 2005, p. 121). Most of the informants in this research project have been in personal therapy themselves to help with their own life problems. Some of them directly refer to these experiences as very important steps in their own development as family therapists.

The map of resonance could also be discussed from an ethical point of view. Some of the categories in the map are closer to ethical considerations than others. Categories like "reciprocal dissonance" and "therapeutic colonization" cover narratives from family therapy practice that needs ethical considerations.

The narratives connected to the map of relational resonance have come forward as a part of this research project. Normally stories like this would only come forward through supervision or personal therapy. We do not have any common standards to refer to regarding

the content of a family therapy education programme in Norway. The question is whether, in addition to PPD work, the time is right to re-introduce discussion and reflection over the need for and benefits of having personal therapy as a compulsory part of the education programme for a student who wants to qualify as a family therapist.

Conclusions

This research project has resulted in the construction of a map of relational resonance. The resonance occurs both in the therapist's mind and emotions and in the relation between the therapist and the clients. This map of relational resonance might be described as a continuum that spans from reciprocal resonance to therapeutic imperialism and includes therapeutic colonialism.

The map of relational resonance may offer both a constructive and a critical perspective to family therapy practice. An in depth discussion of these concepts for understanding and developing systemic family therapy is needed.

The relational map of resonance may also be an important element in family therapy education and training. In understanding and conducting family therapy and systemic practice the relational map of resonance has the potential to be developed as an evaluation tool and a helpful framework for discussing therapeutic practice. Alertness to relational resonance also has implications for supervisors. These are all areas for further research.

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