© The Association for Family Therapy 2002. Published by Blackwell Publishers, 108 Cowley Road, Oxford, OX4 1JF, UK and 350 Main Street, Malden, MA 02148, USA.
Journal of Family Therapy (2002) **24**: 187–204
0163–4445

Some hypotheses about hesitations and their nonverbal expression in family therapy practice

Peter Rober[a]

When people seek therapy they have stories to tell. In the course of the therapeutic conversation the clients continually make selections about what they want to tell, and what they want to keep silent. In this article the author focuses on the border zone between the said and the not-yet-said, and proposes three hypotheses about the client's hesitations about speaking in the family therapy session. In these hypotheses 'hesitation' is used as a metaphor to give meaning to some nonverbal utterances of clients in such a way that space is opened up in a respectful way for as-yet untold stories. I suggest that it is fruitful to think of certain nonverbal utterances of the clients as hesitations to proceed with the conversation, and to use these nonverbal utterances, in the line of Tom Andersen's thinking (1995), as a starting point for a respectful dialogue with the family about the good reasons they might have not to speak. Not only can this open up space for as-yet unspoken stories, it can also help the therapist to establish a collaborative therapeutic relationship with the family. These ideas are illustrated with several case studies.

Introduction

When people seek therapy they have stories to tell. However, in therapeutic conversations there are also stories that are not told. Some stories are not told because the clients do not consider them to be relevant to the concerns that bring them to therapy. Other stories may be relevant but difficult to tell, for instance, because clients judge that the context of the conversation is too unsafe to tell their stories, especially their most vulnerable stories, their stories of doubt and guilt, shame and pain. Rogers *et al.* (1999) recognize a range of unspoken stories: 'From the unsaid (what is simply not said or missing), to the unsayable (what is difficult to say but may be implied through negation, revision, evasion, or silence),

[a] Clinical psychologist and family therapist, Feelings & Context, Troyentenhoflaan, 87 B-2600 Antwerp, Belgium. E-mail: peter.rober@skynet.be

© *2002 The Association for Family Therapy and Systemic Practice*

to the unspeakable (what points to a knowledge that is dangerous or taboo)' (pp. 91–92). Griffith and Griffith (1994) state that in the course of the conversation clients decide which stories to tell and which to hold in silence: clients 'constantly guard against expressing stories that can safely be told only within private, inner dialogues' (Griffith and Griffith, 1994: 40). This process of selection surfaces whenever clients hesitate about speaking in the session. A hesitation may be expressed, not only in prolonged silence, but also in nonverbal signs from the client: a glance, a sigh, a pause in the flow of the conversation, shifting in the chair and so on. Often these are just fleeting nonverbal signs that might pass unnoticed if the therapist does not pay close attention. Such moments of hesitation are important however, since they are moments of evaluation in which the client weighs the safety of the conversational context against the vulnerability of the story she is about to unfold.[1]

In this article I will reflect on the importance of the client's hesitations to speak in the family therapy session as an important tool for the therapist in opening up space for untold stories. I will propose three hypotheses that have been useful to me in my work with families:

1 Clients express their hesitations about telling a story mainly in *nonverbal ways*.
2 When clients hesitate they have *good reasons to hesitate*. Their hesitations often reflect important stories that have not yet been told.
3 In family sessions *children* are often the ones who express these hesitations because they are the most sensitive to possible dangers for the family.

The purpose of this article is to give an account of the constructive contribution these hypotheses can make to family therapeutic practice, in particular in creating opportunities for establishing a collaborative therapeutic relationship with the clients and in helping to open up space for stories that have not yet been told.

Stories and conversations

Anderson and Goolishian (1988) maintain that it is the therapist's task to listen to the client's stories and to help to open up space for

[1] Although I would prefer to write in gender neutral terms, for the sake of readability the client and the therapist are referred to by the feminine pronoun instead of the clumsy 'he or she' and 'his or her'. No gender discrimination is intended.

© 2002 The Association for Family Therapy and Systemic Practice

the *not-yet-said*, or, in other words, for the stories that have not yet been told. However, the relationship between the said and the not-yet-said is not a simple one. Instead, it is a complex, dynamic relationship where what is said can be understood only in the context of what is not said (Rogers *et al.*, 1999), and where what is said reveals and conceals at the same time (Lakoff and Johnson, 1980; Billig, 1997). In this article I want to focus on the border zone between what is said and what is not-yet-said. Indeed, although the client's talk may be impulsive at certain moments during the conversation, there are also moments of reflection in which she pauses and selects what she will say next, and what she will leave unspoken.

The Vansteen family

I was talking with a family in which the father, Kurt had a severe heart attack some months ago, and nearly died. Since that moment he felt like an old man and he was scared to live. The mother, Nancy, told me the story about the changes the heart attack brought in the family. She also mentioned how it had affected their only son, Sid.

Then she said: 'Next week there will be another medical check up of Kurt', and glanced sideways at her husband. Then she fell silent. The silence lasted for perhaps one or two seconds, but it somehow felt to me that Nancy hesitated to proceed with the telling of her story.

As happened in this session, it is not uncommon that a client makes a pause in the conversation as she hesitates to speak. Tom Andersen (1995) states that, at moments in which the client pauses, she seems to shift between outer conversation and inner conversation. The silence then is the expression of an inner reflection in which the client searches for the best way to express herself (Andersen, 1995). At the same time this pause also creates a space in which the client, in her inner conversation (Rober, 1999), decides which story she will tell, and which story she will, at least for now, hold in silence (Griffith and Griffith, 1994). The client asks herself: 'Will I tell this, to this therapist, at this moment in the session?' In that sense, such a pause may be seen as a hesitation to speak.

As is illustrated in the example of Kurt, Nancy and Sid, a hesitation is often expressed in a nonverbal way. This may be understood if a hesitation is conceptualized as a compromise between two movements: the movement towards speaking, and the movement

© 2002 The Association for Family Therapy and Systemic Practice

that holds back the words. The compromise is a nonverbal expression. Nonverbal expressions are sometimes very subtle and might pass unnoticed if the therapist does not pay close attention. Paying close attention to nonverbal signs used to be self-evident in family therapy, but ever since narrative metaphors like story and conversation were used as an epistemological foundation for clinical work, the importance of nonverbal communication risks being underestimated in family therapy. Indeed, the use of narrative metaphors as 'metaphors to live by' (Lakoff and Johnson, 1980) seems to invite therapists to focus their attention on 'words', 'voices' and 'talk'. As a consequence, they limit their field of study to what is being *said*, and the nonverbals are left in obscurity.

Nonverbals obscured

Perhaps this deserves some additional explanation. The concept of '*metaphor to live by*' was originally described by Lakoff and Johnson (1980). Primarily on the basis of linguistic evidence, Lakoff and Johnson stated that metaphors are not mere poetical or rhetorical decoration but a part of our language that affects the way we perceive, think and act. Furthermore, they talked of *metaphorical systematicity*. By this concept they mean that a metaphor always highlights an aspect of our experience, and leaves something else in obscurity. In family therapy the metaphor 'system', for instance, highlights the interaction between the family members, but it obscures the randomness of family events and the extent to which system analysis involves observer subjectivity (Rosenblatt, 1994). Another example: the cybernetic metaphor, on the one hand, helps us see circularity and feedback loops in family life, but on the other hand, it obscures personal responsibility and power inequality. In this way every metaphor highlights some part of our experience, and leaves another in the dark.

If we accept these ideas of Lakoff and Johnson (1980), it is justifiable to ask the question: What might narrative metaphors (text, stories, conversations . . .) leave in obscurity when we use them as an epistemological foundation for a collaborative family therapy? Minuchin (1998) tried to answer this question in an article entitled 'Where is the family in narrative family therapy?', and he stated that the use of narrative metaphors in family therapy obscures the family:

© 2002 The Association for Family Therapy and Systemic Practice

> Narrative therapy has moved away from systemic principles in order to highlight context and culture, but there is something paradoxical in this movement. In the process, theorists seem to have misplaced the family – that prominent, intermediate locus of context and culture within which people live.
>
> (p. 403)

Reading through the collaborative literature, it seems that another aspect of the family therapy practice may be obscured within a narrative paradigm: the importance of nonverbal communication. It is striking that in the literature of the collaborative therapies (e.g. White and Epston, 1990; de Shazer, 1994; Freedman and Combs, 1996; Zimmerman and Dickerson, 1996; Anderson, 1997) non-verbal behaviour is barely mentioned. For instance, in *If Problems Talked: Narrative Therapy In Action* (1996), Zimmerman and Dickerson's wonderful and courageous book on narrative therapy, '*talk'* is omnipresent, and the authors never mention nonverbal communication. Even in the chapter on narrative therapy with children, entitled 'Just let children talk', they never mention the importance of nonverbal communication in working with children and they only give examples of stories which children tell verbally. This illustrates how narrative metaphors tend to focus our attention on verbal behaviour (the story the clients tell), and may cause us to underestimate the importance of nonverbal behaviour (the story the clients show). This is clearly the case in Steve de Shazer's book *Words Were Originally Magic*, in which de Shazer favours the *text*, which he defines as 'what is actually said' (de Shazer, 1994: 75). He seems very suspicious of considering nonverbal communication as meaningful or useful. This is evident, for instance, in his comments on a case study of Nathan Ackerman. When Ackerman saw a grin of the son as a sign of disagreement with the father, de Shazer comments, 'But where does Ackerman get this idea that the son disagrees? Certainly not from anything *said* so far' (de Shazer, 1994: 69). He writes that therapists 'just got to listen to what the client says' (p.109).

De Shazer's neglect of the importance of nonverbal communication may be understood against the background of his commitment to post-structuralist philosophical ideas and his rejection of structuralist thinking (de Shazer, 1994). Structuralists try to know the world 'as it really is', through detailed observation and interpretation. Structuralist thinking is based on the ideas of the Swiss linguist de Saussure who made a distinction between *signifiant* (signifier)

© *2002 The Association for Family Therapy and Systemic Practice*

and *signifié* (signified). The *signifiant* is the word (for instance, 'dog'), and *signifié* is the concept to which the word refers (a pet that barks and wags its tail). The *signifiant* and the *signifié* are linked in an arbitrary way, but the link is fixed by cultural and linguistic traditions. In this view meanings are expressed by means of a code. The listener (or the scientist, the therapist, the reader and so on) has to interpret the code to gain access to the underlying meaning. De Shazer rejects the structuralist view that nonverbal behaviour refers to some underlying meaning, which has to be decoded by an expert. Instead he embraces a post-structuralist perspective inspired by Derrida and Wittgenstein. He rejects the split between subject (expert–therapist) and object (the family), and advocates a system-wide co-operation that is deemed central to effective therapy (de Shazer, 1991: 57). In line with this rejection of a structuralist perspective, de Shazer focuses on *solutions* instead of on problems, on *the present* instead of on the past, on *exceptions* instead of on repeating patterns, on *'what the client says'* instead of on what is unspoken.

Wordless is not worthless

However, not all collaborative therapists consider 'what the client says' as the only relevant focus for the family therapist in the therapeutic conversation. Tom Andersen (1995), for instance, stresses that the therapist not only has to listen to all the spoken, but also has to see how it is uttered: 'To hear is also to see', Andersen writes (1995: 23). He gives an example of a father who sighs when he speaks about his son's sadness. This was an invitation for Andersen to start a conversation about sadness, and he asked: 'When your son is sad, is his sadness totally filled with sadness or are there other feelings in his sadness?' The father says, 'there's also anger.' Andersen goes on and asks, 'If your son's anger could speak, what would the words be?' and so on. With these kinds of questions Andersen is not searching for what the real meaning is behind or under the expressed, as would a structuralist. Instead, he wants to understand what's *in* the expression (Andersen, 1995). He focuses on the richness of the nonverbal utterances and sees them as invitations for further curious and respectful questioning.

When we return to the case of the Vansteen family we see that the therapist, inspired by Tom Andersen's questions, took Nancy's prolonged silence as a departure point of a respectful dialogue:

© 2002 The Association for Family Therapy and Systemic Practice

The Vansteen family (part 2):

I let the silence be for a moment and then I asked Nancy:
'If this silence could speak, what might the words be?'
'I don't know . . . I don't want to scare him. [She nods at Kurt] He is scared as it is, and if I would tell about my fears. . . .'
'Are you afraid that he might become even more scared if you would tell about your fear?'
'Yes.'

Sometimes hesitations to speak in therapy have been interpreted as defences of the clients: the client resists the therapeutic process by saying nothing. In that perspective silence is seen as an absence: the absence of words. Other authors however have stated, 'Silence takes on many different shades and tones' (Serani, 2000: 505): silence in therapy may mean many different things to many different clients. Social constructionism has taught us that meaning is not discovered in the intention of the client. Rather it is created by a kind of negotiation in the dialogue between the therapist and the client (Gergen, 1999). In the case of the Vansteen family the meaning of Nancy's silence was created by the silence on the one hand, and on the other hand by the therapist's response. The therapist did not view this silence as an absence but as a presence: silence is full of unspoken stories and reasons why they are kept unspoken. The therapist considered Nancy's silence to be a reflection of her hesitation to speak: there is something she wants to express, but there is something that is holding back the words. He asked a question about this silence: 'If this silence could speak, what would the words be?' Nancy's answer illustrates that she accepts the therapist's proposal that her silence was not empty. She accepted that the therapist's idea of the silence as a hesitation to speak about her own fears made sense, and she made it clear that she had good reason to hesitate: she did not want to scare her husband more than necessary.

This simple example highlights the first hypothesis of this article: The hesitation of a client to proceed in the conversation is often expressed in nonverbal ways (for instance, silence). It also illustrates the second hypothesis: Clients have good reasons to hesitate. Sometimes speaking is dangerous (Griffith and Griffith, 1994), and the speaker could hurt someone in the family or she could be hurt herself.

© 2002 The Association for Family Therapy and Systemic Practice

Hesitations in the family session

John Byng-Hall described how a child can become a distance regulator in the family (Byng-Hall, 1980, 1995): 'The child monitors the parents' relationship, ready to pull them together when they get too distant or come between them when they get too close. Family therapists know only too well the myriad ways in which children can be involved in these maneuvers' (Byng-Hall, 1995: 185). In a similar way children often become regulators of what is talked about in the family therapy session by expressing hesitation to proceed with the conversation. Indeed, in a family session hesitations are not always expressed by the person speaking. Sometimes, while one family member is telling a story, another family member (usually a child) shows a nonverbal sign that may be understood as a hesitation to proceed in the session. This is the third hypothesis of this article. It is inspired by the work of Edith Tilmans-Ostyn (1999a) who talks about the 'brakes' of the family. She states that children through their nonverbal behaviour often signal the dangers of conversational exploration of certain themes during the session. It is as if the child's nonverbal behaviour expresses a hesitation to proceed with the conversation. When the child starts to make a noise or asks to go to the toilet, or when the child distracts her parents and so on, it is as if the child seeks ways to slow down or even stop the conversational movement. In that sense, these utterances of the child may be understood as nonverbal comments on the course of the conversation: 'This could be dangerous', 'this goes too fast', 'this is not a safe theme to talk about' and so on. The following case example illustrates this very clearly.

Case study of Tom

It was the first time that 8-year-old Tom and both his parents were together in the same room since the parents had separated two years before. They entered the room silently. They seemed cautious. Father sat down in the chair on the right. Mother in the chair on the left. Tom sat in the middle. I wondered in my inner conversation how he would feel, sitting between his parents: Was he a bridge between them or was he a fence?

Tom was referred to me by his GP because of stomach aches. The doctor had found no physical grounds for the pains, so he sent Tom and his parents to me. We sat quietly at first and then we spoke about the concern of the parents for Tom's mysterious pains. I felt uncomfortable and I sensed that this talking was in some way a subtle fight between the

© 2002 The Association for Family Therapy and Systemic Practice

parents. They talked pleasantly, but they were reproaching each other all the time. It was strange, because they did not look at each other as if they had not yet noticed that the other was there too. Minute by minute I felt the tension between the parents rise. I did not think that our conversation would last an hour without there being an outburst of violence between the parents. It seemed unavoidable. I wondered how Tom would be feeling, and at that moment I saw that Tom was holding his stomach with both his arms. 'Is he in pain?' I asked myself. Then I looked at the parents to see if they were alarmed too, but they were not.

Then father said to me: 'Of course it's up to you to find out what is wrong with Tom.'

What could I say without taking sides? I wondered. I felt stuck between both parents and I suddenly realized that this must be how Tom had been feeling. I looked at Tom again, and now his face told me he was in pain, so I asked him: 'Are you in pain?'

He didn't say a word but nodded yes. I invited him to sit next to me and to tell me about his pain. He stood up and came to sit down next to me.

'Can you tell me about your pain?' I asked him.

'It is better now,' Tom answered.

'That's good,' I said, and I felt Tom's relief. I hypothesized that his stomachache was probably an expression of the tension he was feeling, sitting between his parents. I decided to ask him about it.

'Can you tell me the story your pain is trying to tell us?' I tried, but I sensed that Tom would not be able to talk about it at that moment. And indeed he didn't answer. So I again turned to the parents and we started to talk about how difficult it was for them to be parents for Tom while separated. I noticed that, at least for the moment, the tension between the parents had gone. Both had been listening attentively to Tom and to me. I made a mental note that Tom's stomach ache had at least attracted attention to him, and in that way had avoided the possibility that the tension between his parents would rise so much that it might erupt in violence.

As Tom's story illustrates, in some cases the symptom of a child manifests itself in the session as a nonverbal behaviour that may be understood as expressing a hesitation to proceed with the conversation. It is as if Tom wanted the therapist to know that it would be dangerous to proceed in the session because there was the possibility of an aggressive outburst or a fight between his parents. The therapist used Tom's nonverbal behaviour as a starting point for a dialogue. This is often a useful way to open up space for untold stories. It is important however that the therapist respects the tempo and vulnerability of family members (Rober, 1998). Indeed, sometimes family members show things in nonverbal ways before they, or other family members, are ready to talk. This seemed to be the case with Tom's

© 2002 The Association for Family Therapy and Systemic Practice

stomach ache. The therapist initially thought that by mentioning the stomach ache space could be opened up to talk about the unspoken tension Tom was feeling during the conversation between his parents. On second thoughts however, the therapist did not want to pressure him to speak because he reflected that if Tom's stomach spoke instead of his mouth, there would probably be a good reason for that. It might be that, at least at this moment, it was too difficult or too dangerous to put the story into words (Griffith and Griffith, 1994). In cases like this, it may be the best option for the therapist to ignore the nonverbal utterance or to comment on it 'with a tentative uncertainty in order to help the family to become more sensitive to things previously unnoticed' (Andersen, 1987: 420).

Good reasons not to talk

Instead of focusing on the content of the unspoken story, I propose that the therapist should invite family members to talk about the good reasons (Tilmans-Ostyn, 1999a) they have not to tell the story. The therapist might say: 'I understand that you don't want to talk about it now. That's OK. But could you help me to understand what makes it so difficult to talk about it now?', or 'What do you fear might happen?' These kinds of questions reflect a genuine respect of the therapist who explicitly gives the clients the right to decide for themselves whether or not they want to talk about something. Furthermore, the therapist acknowledges that the clients have good reasons for their decision not to tell the story, and she wants to try to understand the importance of these good reasons. This respectful and reserved approach often opens up space for other untold stories that highlight the need clients have to try to protect themselves by keeping certain stories silent. This is illustrated in the case study of Elly and the hypodermic needle.

Case study of Elly and the hypodermic needle

A divorced mother, her 8-year-old daughter Elly and her 2-year-old son Art came to family therapy because the mother was concerned about the behavioural problems of her daughter. The mother also said that she herself had been hospitalized with severe depression some months ago, and she indicated that she also wanted some individual sessions for herself to talk about her painful childhood. Her mother had died when she was 8 years old, and she had felt very lonely as a child.

© 2002 The Association for Family Therapy and Systemic Practice

At the end of the second session the mother suggested that Elly might benefit if she could talk alone with a therapist about her father and how she had missed him since their divorce. I turned to Elly and asked her what she thought about the mother's suggestion. Elly shook her head. I asked her if she could help me understand her gesture. Elly reluctantly said that she did not want to talk about her father because it would make her feel very sad. I said that if she did not want to talk about her father I would respect that, but I added that if she wanted to change her mind and decide she did want to talk about her father, she could. Elly nodded. Then I asked the mother if she thought it was time for her to talk, without the children, about her painful childhood as she had asked in the first session. The mother said that indeed she wanted to talk about her childhood. It was then that Elly stood up and playfully gave her mother an injection with a toy hypodermic needle. The mother interrupted what she was saying and said jokingly 'Aw, you're hurting me!' We all looked at Elly.

When Elly gave the injection to her mother, my first thought was 'this is important'. In my inner conversation I wondered if Elly perhaps wanted to draw our attention away from the painful subject the mother was talking about to the here-and-now that was less painful. Another hypothesis that popped into my mind was that perhaps this was Elly's way of symbolically helping her mother to feel less pain about her miserable childhood (the injection being a pain-killer). Indeed, Elly had just said she did not want to talk individually about issues that mattered to her because she would feel too sad. Perhaps she thought her mother would be sad too when she talked about her childhood.

I playfully asked Elly: 'Do you want your mother to feel less pain?'

Elly smiled but said nothing. Then I told her about some of my reflections. I told her that she had struck me as being a very helpful person and that perhaps she thought it would be painful for her mother to talk alone, and so she wanted to give her mother a pain-killer.

Elly answered that she didn't want her mother to talk with me alone about her painful childhood.

I asked if she could help me to understand that. She remained silent. I asked: 'Do you think it will be too painful for her to talk about her childhood?' She nodded yes.

The mother said to Elly: 'But if I would talk about it, the pain would eventually go away.'

Elly shook her head and said: 'If you would talk about those painful things, where would I have to stay?'

At first I was confused by Elly's remark. Then I realized that Elly was probably referring to the three months that her mother had been hospitalized with depression. Elly had to stay in a home during that period. I asked her if she was afraid her mother might have to be hospitalized again if she would speak about her painful childhood. She nodded yes.

© 2002 The Association for Family Therapy and Systemic Practice

Elly's affirmative answer acknowledges to the therapist that it made sense to understand her playfully injecting her mother as a hesitation to proceed with the conversation. Elly appeared to be very sensitive of the dangers for her mother of talking individually with the therapist as she feared that her mother might become depressed again. These were Elly's good reasons to hesitate.

Hesitations at the beginning of therapy

Hesitations can often be observed, not only in the course of the conversation, but also right at the beginning of the therapeutic encounter, when therapist and client meet for the first time: for instance, when the client is waiting in the waiting room or when she is sitting in front of the therapist for the first time and is confronted with her own intention to tell her story. She feels the vulnerability of the stories she is about to unfold, and she wonders if the conversational context will be safe enough: Will the therapist understand? Will she laugh at me? Will she consider me crazy? Will I lose control of my emotions? And so on. Clients seldom say these things out loud, but still they hesitate, and the hesitation often shows in subtle, nonverbal ways that are not easy to grasp. This is illustrated in the case study of 25-year-old Liza, who came into therapy because she had been abused as a child by her father.

Case study of Liza

When Liza entered the consultation room at the beginning of the first session I felt a vague uneasiness. This uneasiness did not pass. At first I could not put my finger on it. I wondered what was wrong. I told myself to take some distance and to focus on my inner conversation. It was not what she said that made me uneasy, rather it was how she said it. Her answers were rather brief. She looked very tense. I also noticed that she looked away and made no eye contact. I reflected that she looked irritated, and that made me feel that she did not trust me. I reflected that, although we had not met before, perhaps she was angry with me. Perhaps it was something I had said that had hurt her or perhaps it was something else. Perhaps she was just tense, as some people are at the beginning of a therapy.

I asked Liza if she was feeling tense.

At first she was silent, but then she said that it was not easy for her to come to therapy.

'Can you help me understand that?' I asked.

Liza answered that she had been thinking about going into therapy for

© 2002 The Association for Family Therapy and Systemic Practice

a long time, but she had always postponed it: 'Even just now, while I was sitting in the waiting room, I contemplated walking out again,' she added.

I again asked her if she could help me understand.

Then she told me the following story: 'My father has abused me the first time when I was 4 or 5 years old. He came to my room at night when everyone in the family was asleep, and he raped me. Afterwards he said to me that I should never talk about it, because it was our secret and if I would talk he would have to go to gaol. So I did not talk about it but the following nights he came again, and every time he raped me. One night I had wetted my bed. When father came and he noticed the bed was wet, he got angry with me, and he called me a filthy, dirty slut, but he did not rape me. So I had found a way to protect myself against him. Since that night I wetted my bed every night.

Soon my mother noticed I was wetting my bed. So she talked to the GP and he referred us to a therapist. When my mother told me we would go to a therapist, I felt my hopes rising. Maybe now there would come an end to the pain, the fear and the shame. In the first session however I noticed that the therapist was only concerned in finding a solution for my bed-wetting. He did not seem at all interested in the family relations or in the how and why of the bed-wetting. I have to admit that in some way that was a relief, because I feared the confrontation with my father. At the same time I was very angry with the therapist, not only because he did not notice that there was more to it than just bed-wetting, but also because he was searching for a solution for the bed-wetting and he did not seem to notice that he was going to take away the only protection I had against my father.

So I sabotaged the solutions he proposed, and I also swore I would never trust a therapist again.'

Liza's story moved me very much. I thanked her for sharing her story with me. Then we started talking about trust and about how she could protect herself from being hurt again by a therapist.

Liza's story about her childhood experiences can teach us a lot about the importance of nonverbal communication (in this case: her symptom, bed-wetting) in family therapy practice. It shows that nonverbal behaviours of children often touch upon unspoken stories in the family. The nonverbal behaviour seemed the best way of saying what could not be said, since talking was forbidden and unsafe (Griffith and Griffith, 1994). The fact that little Liza's nonverbal signs were not taken seriously, nor understood by the family therapist, was very disappointing for her. Furthermore, her hesitation (fearing the confrontation with her father), which was expressed in her sabotaging the therapy, was also left unspoken. It is likely that the therapist has experienced her as a difficult, resistant child.

© *2002 The Association for Family Therapy and Systemic Practice*

The session of the adult Liza with the therapist highlights the importance of taking nonverbally expressed hesitations at the beginning of a therapy seriously, since they usually refer to important personal stories that have not been told before. As in Liza's case, hesitations at the beginning of a therapy often refer to earlier unpleasant or even traumatic experiences with therapy (Tilmans-Ostyn, 1999a). These negative experiences with therapy can make a client feel extra sensitive and vulnerable. Opening up space for these stories maximizes the chances that this new therapeutic encounter will be collaborative and fruitful, not only because it gives the therapist the opportunity to be extra careful about the sensitive spots of the client, but also because she can make space for something new by ensuring that the negative experiences will not be repeated in this new therapeutic process (Tilmans-Ostyn, 1999a). The telling of the story of the negative experiences sometimes suffices for clients to reassure them that the experience will not be repeated. By telling the story, the new therapeutic process becomes differentiated from the old one, and space is opened up for new experiences.

Sometimes, however, it is not enough for clients to just tell the story to be freed from their preoccupation with past experiences. In those cases, the therapist can discuss with other family members what could reassure them that the same bad thing will not happen again when they risk themselves in a new therapeutic process. As is illustrated in the next case study, the dialogue about this question can give clues about what is needed for the client to feel safe in the therapeutic dialogue.

Case study of Sam and the proclamation of martial law

A family came to therapy because 12-year-old son Sam ran away from home. When the police found him he claimed that he had been kidnapped. The police did not believe his story and brought him back to his parents. They also contacted the school psychologist. The school psychologist talked with Sam but, because Sam mentioned family problems, he referred Sam and his family to me.

In the first session Sam was silent. He didn't want to talk. I asked him if he could help me understand his silence. Sam looked at his father and kept silent. I said: 'Sam, I'm not sure, but I got the impression that you don't want to talk. That's OK. You don't have to talk.'

I paused and then I said: 'Let me tell you a little story. Here, look at this turtle. [I showed him a toy turtle] Whenever a turtle feels that it is unsafe

© 2002 The Association for Family Therapy and Systemic Practice

it retracts its head and its legs in its shield. [I showed him how the turtle retracts its head and legs] In that way the turtle cannot be hurt. That's the way a turtle protects itself from being hurt. Now children don't have such a shield. You know how children often protect themselves when it is not safe? They don't say anything. They keep quiet and wait until it is over. So when you are quiet like that, I am wondering if you are feeling unsafe, I am wondering if you ever had the experience that something bad happened after you talked about something?'

Sam again looked at his father and also at his mother. I got the impression that Sam was interested in this kind of question. Then Sam took a breath as if he was going to say something, but I interrupted him: 'No, wait, you don't have to answer me. Only answer me if you feel safe enough.'

Sam nodded. Then he said that he had felt safe to talk with the school psychologist, but now, with his parents present, he didn't want to talk. We talked about the difference between talking individually with a therapist and talking with parents present in a family therapy. Soon it became clear that Sam was concerned about his father who might become depressed again if they talked. The parents explained that the father had been hospitalized several times with severe depression. The father said that he himself had been tense about going to a therapist because he was afraid that talking might evoke his depression again: 'I went to therapy once, but the more I talked, the more I started to feel depressed again. So I didn't go to therapy anymore,' he explained.

I asked them what would reassure them that the same thing would not happen here in these family conversations.

Sam said: 'If we would all be vigilant to see the first signs of the depression.'

'To watch for warning signs?' I asked.

Sam nodded.

Then I asked: 'What would be the first warning signs that the depression might creep up again on father?'

Sam and his parents talked about 'not wanting to get up in the morning', 'feeling tired all the time', 'talking less with us', 'talking less positively about himself', 'no longer enjoying reading the newspaper', 'not going out fishing with his buddy', 'sighing a lot', 'drinking more'.

I took notes of these signs. I proposed to make a scale that would assess these warning signs. At the beginning of every session the family members would each score these items on a scale from 1 (no alert at all) to 10 (red alert). Then I asked, if the scores to this assessment scale were to start to be alarming (6 and higher), how should we react, what should we do?

'We proclaim martial law,' Sam exclaimed.

Everybody laughed.

We talked about what 'martial law' might mean for this family and then the family members decided that under 'martial law' the sessions would have to stop being very emotional and 'deep', father would have to contact

© *2002 The Association for Family Therapy and Systemic Practice*

his psychiatrist to talk about taking medication, he would also have to talk to his wife about what bothered him, and he would have to think about positive aspects of himself and the world around him and discuss it with his family.

After the session I made a contract in which I clearly stipulated the agreements we had reached. As agreed with the father, I also contacted his psychiatrist to explain what we would be doing in the family therapy. The next session everybody was given a copy of the contract, as well as a copy of the assessment scale to score. This procedure made talking in the family safer for everybody. It also helped the therapist to establish a therapeutic relation of collaboration with the family. During the whole therapy the assessment scale was scored and the alarm threshold was never reached.

Discussion

In this article I have advocated that it is sometimes fruitful to think about nonverbal utterances of clients as hesitations to proceed with the conversation and to use these nonverbal utterances, in line with Tom Andersen's thinking (1995), as a starting point for a respectful dialogue with the family. It is important however to highlight that I do not propose that the therapist should start to talk about her hunches or suppositions about the client's untold stories. On the contrary, I suggest that the therapist should be very respectful towards the untold story, and that the dialogue should be focused on the hesitations and the good reasons clients may have not to speak. This genuinely respectful and reserved therapeutic approach often creates a context in which clients feel safe to start to talk about their more vulnerable stories. Furthermore, it also helps the therapist to establish a collaborative therapeutic relationship with the family.

In concluding, it may be important to acknowledge that, although I hypothesized that clients often express their hesitation in nonverbal ways, this does not mean that all hesitations are expressed nonverbally. Sometimes clients just say, 'I'm not sure I want to talk about this because . . .'. Often, however, such a verbally expressed hesitation is announced by nonverbal signs. Children are usually the ones who express these hesitations nonverbally, because they 'bathe in the emotional climate of the family' (Tilmans-Ostyn, 1999b: 90). This gives the therapist the opportunity to invite the child to become a consultant (Andolfi, 1995) in the therapeutic conversation. The child hesitates and signals in a nonverbal way

© 2002 The Association for Family Therapy and Systemic Practice

possible dangers, and the therapist uses the child's nonverbal signs as a starting point for further dialogue, not about the dangerous theme, but about the hesitations and about the good reasons family members have not to speak.

In their writings, collaborative therapists have not been paying sufficient attention to the nonverbal behaviour of clients. This may be understood against the background of their commitment to post-structural and postmodernist philosophies, as well as their suspicion of therapists' knowledge and power. The therapist is not the expert, but the client is, collaborative therapists rightly state, and the client's story is considered to be of central importance. However, part of the client's story is told in nonverbal ways. Not paying attention to nonverbal signs of the family members can leave important stories untold. Genuinely listening to the client's story means listening to the simultaneous presence of both what is said and what is expressed nonverbally, and to the interplay between the two. In that way, what is expressed nonverbally can become a door that gives access to explore the complex layers of the family members' experiences and understanding and, perhaps more importantly, it can help to establish a fruitful collaborative therapeutic relationship.

Acknowledgements

I thank Edith Tilmans-Ostyn (Université Catholique de Louvain, Brussels, Belgium), Michael Seltzer (Oslo University College, Norway), Craig Smith (San Diego State University, USA) and Tom Strong (University of Calgary, Canada) for their valuable comments on an earlier draft of this paper, as well as for their helpful suggestions.

The central ideas of this article were first presented at the IFTA Family Therapy World Congress in Oslo, Norway (June, 2000).

References

Andersen, T. (1987) The reflecting team. *Family Process,* **26**: 415–428.

Andersen, T. (1995) Reflecting processes; acts of informing and forming: you can borrow my eyes but you must not take them away from me! (pp. 11–37). In: S. Friedman (ed.) *The Reflecting Team in Action: Collaborative Practice in Family Therapy.* New York: Guilford Press.

Anderson, H. and Goolishian, H. (1988) Human systems as linguistic systems. *Family Process,* **27**: 371–393.

© *2002 The Association for Family Therapy and Systemic Practice*

Anderson, H. (1997) *Conversation, Language and Possibilities: A Postmodern Approach to Therapy.* New York: Basic Books.
Andolfi, M. (1995) The child as consultant. In M. Andolfi and R. Haber (eds) *Please Help Me with this Family.* New York: Brunner/Mazel.
Billig, M. (1997) The dialogic unconsciousness: psychoanalysis, discursive psychology and the nature of repression. *British Journal of Social Psychology,* **36**: 139–159.
Byng-Hall, J. (1980) The symptom bearer as marital distance regulator: clinical implications. Family Process, **19**: 355–365.
Byng-Hall, J. (1995) *Rewriting Family Scripts: Improvisation and Systems Change.* New York: Guilford Press.
de Shazer, S. (1991) *Putting Difference to Work.* New York: W. W. Norton.
de Shazer, S. (1994) *Words Were Originally Magic.* New York: W. W. Norton.
Freedman, J. and Combs, G. (1996) *Narrative Therapy: The Social Construction of Preferred Realities.* New York: W. W. Norton.
Gergen, K. J. (1999) *An Invitation to Social Construction.* London: Sage.
Griffith, J. L. and Griffith, M. E. (1994) *The Body Speaks: Therapeutic Dialogues for Mind–Body Problems.* New York: Basic Books.
Lakoff, G. and Johnson, M. (1980) *Metaphors To Live By.* Chicago, IL: University of Chicago Press.
Minuchin, S. (1998) Where is the family in narrative family therapy? *Journal of Marital and Family Therapy,* **24**: 397–404.
Rober, P. (1998) Reflections on ways to create a safe therapeutic culture for children in family therapy. Family Process, **37**: 201–213.
Rober, P. (1999) The therapist's inner conversation: some ideas about the self of the therapist, therapeutic impasse and the process of reflection. *Family Process,* **38**: 209–228.
Rogers, A. G., Casey, M. E., Ekert, J. Holland, J., Nakkula, V. and Sheinberg, N. (1999) An interpretive poetics of languages of the unsayable (pp. 77–106). In R. Josselson and A. Lieblich (eds) *Making Meaning of Narratives.* London: Sage.
Rosenblatt, P. C. (1994) M*etaphors of Family Systems Theory: Toward New Constructions.* New York: Guilford Press.
Serani, D. (2000) Silence in the analytic space, resistance or reverie? *Contemporary Psychoanalysis,* **36**: 509–519.
Tilmans-Ostyn, E. (1999a) La Démarche vers le Thérapeute: de la plainte à la demande (pp. 71–84). In E. Tilmans-Ostyn and M. Meynckens-Fourez (eds) *Les Ressources de la fratrie.* Toulouse: Erès.
Tilmans-Ostyn, E. (1999b) Quand la Démarche Parentale vers la thérapie est centrée sur un enfant (pp. 85–110). In E. Tilmans-Ostyn and M. Meynckens-Fourez (eds) *Les Ressources de la fratrie.* Toulouse: Erès.
White, M. and Epston, D. (1990) *Narrative Means To Therapeutic Ends.* New York: W. W. Norton.
Zimmerman, J. L. and Dickerson, V. C. (1996) *If Problems Talked: Narrative Therapy in Action.* New York: Guilford Press.

© 2002 The Association for Family Therapy and Systemic Practice