Decentring Research: Reflecting On

Reflecting Teams

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To the memory of the "Friday Morning Team".

Abstract

This dissertation is an interview based qualitative research study into reflecting team practice. The central question posed is "What can therapists learn from reflecting on their own and their clients' experience of therapy?" Interviews with three clients and two therapists were recorded and transcribed for research purposes. Interview questions were derived from key themes identified in the literature: becoming a client; the experience of self; the experience of the therapeutic relationship; the experience of specific therapeutic practices; and the experience of outcomes. Drawing on White and Epston (1990) the author develops a decentred approach to research practice that is congruent with the values and philosophy of reflecting teams and narrative therapy.

A key finding to emerge from this study is the importance of paying attention to the client's experience of the therapists; the therapists' experience of self; and the therapists' experience of their relationship to their colleagues on the reflecting team. According to both therapists and clients interviewed for this study it is important for the therapists to be there as 'persons' not just as 'professionals'. For example, one of the therapists interviewed spoke of reflecting from "the heart" rather than doing "technique-driven" reflections. Also, the clients spoke about the importance of the "down-to-earth" way in which the therapists communicated. This helps both to establish a positive relationship and to decentre the 'professional knowledge' of the therapist. The degree of comfort and trust experienced by members of the reflecting team with each other also seemed to enhance the experience of therapy for *all* participants. The findings support the use of reflecting teams in agencies as a form of brief therapy *and* as a means of ongoing professional development. They also support the findings of previous research

that we need to pay more attention to how the therapeutic relationship operates in a reflecting team context (Gaddis, 1998; 2002).

Furthermore, these findings suggested that the process of participating in these research interviews was helpful to both therapists and their clients. To therapists, in the sense that the process helped them to put into words their practice wisdom, by reflecting on their own practice and the experience of their clients; to clients, in the sense that it complemented the therapeutic process they were involved in and gave them the opportunity to give something back to others.

The findings are examples of local knowledge only, and make no validity claims to universal truth status. Claims made cannot therefore be generalised to other practice contexts. However, the author draws a number of implications for clinical and research practice from the findings and these are discussed in detail in chapter five. The author acknowledges that these implications are based on his own subjective reading of the findings and practitioners are invited to reach their own conclusions as to the relevance of these findings for their own practice.

Declaration

I certify that this dissertation contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text.

I give consent to this copy of my thesis, when deposited in the University Library, being available for loan and photocopying.

Andrew John Tootell

18 August, 2004

I believe that this dissertation is properly presented, conforms to the specifications for the dissertation and is of sufficient standard to be, *prima facie,* worthy of examination.

Prof. Robert Barrett

26th August, 2004.

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CHAPTER FOUR: RESEARCH FINDINGS

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CHAPTER ONE: INTRODUCTION

While writing this dissertation I worked as a social worker in child and adolescent mental health. When I started working in child and adolescent mental health in 1998, my work was primarily influenced by narrative therapy practices, having completed a Graduate Diploma in Narrative Therapy at Dulwich Centre Adelaide in 1998. It was at the Dulwich Centre that I experienced my first "reflecting team". Reflecting teams interested me as a topic for my research because I was curious to understand more about how it was these conversations were so transformative and moving in their, often, dramatic impact on all participants. Perhaps more than any other therapy process, reflecting teams decentre the professional knowledge of the therapists (exposing them as persons) and utilise the potential of reflexivity to generate therapeutic outcomes.

In the early stages I read a book on practitioner research in counselling and psychotherapy which encouraged me to develop a qualitative approach to doing research that was congruent with my approach to therapy[1] (McLeod, 1999). The writing up of the research became an increasingly reflexive practice, helping me to think about my own practice as a therapist. Indeed, the practice of therapy and the practice of decentred research (and supervision) are at times so closely related that it is difficult to distinguish between them. The influence of narrative therapy will be evident throughout this dissertation.

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[1] From now on I will use the term 'therapy' to refer to both individual, couple and family counselling and psychotherapy.

Writing the second chapter helped to situate my concerns within the European intellectual tradition that has attempted to find methodological foundations for the "human" sciences in order to place them on an equal footing with the "natural" sciences. This broad tradition includes various schools of thought such as hermeneutics, phenomenology, structuralism and post-structuralism. I followed the work of Jerome Bruner (1986; 1987; 1990) in making a distinction between paradigmatic ways of knowing (logico-scientific) and narrative ways of knowing. I then explored the relevance of narrative ways of knowing to practitioner research in therapy. A literature review of research into both client and therapist experience of individual therapy and reflecting teams follows. Much of this research has been conducted with individual-based therapy only. However, after immersing myself in these writings I felt the findings were applicable to relational therapies and reflecting teams. One of the central theoretical concerns addressed in chapter two is the relation between language and experience, and in particular, the way in which language functions to organise or construct, as well as represent and express, our experience (White & Epston, 1990).

Chapter three documents my search for an appropriate methodology consistent with my values and therapeutic orientation. My search takes me beyond procedural method towards a *decentred research practice*, a term I borrowed from narrative therapy practices (White, 1997). In a decentred research practice the theoretical assumptions informing the researcher's questions are made visible throughout the dissertation, and research participants are involved in the analysis of the data. Data analysis, like data production, then becomes a reflexive dialogical process. The de-

centring of the research process requires the development of alternative means of justifying and evaluating research outcomes. The chapter therefore concludes with an outline of some alternative principles to traditional notions of validity and reliability.

It was while working in a position with a child and adolescent mental health agency in Adelaide that I met the therapists who are featured in this dissertation. They have both given their consent for their real names to be used in this dissertation. The therapists then arranged for me to meet their selected clients. The client's names are fictionalised in order to preserve anonymity. Chapter four re-presents in a condensed format a summary (with selected transcript) of my interviews with clients and the research letters that I wrote to the therapists after analysing the transcripts of their interviews into meaning units. The summaries and the letters stay as close as possible to the actual words used by clients and therapists and as such constitute the "findings" of the research.

Chapter five concludes the dissertation. In this chapter I discuss the significance and the implications of the findings for clinical and research practice. The clinical implications are discussed following the lines of inquiry identified in the literature: the experience of self, and the experience of therapeutic relationships, outcomes and practices. One of the key implications for research practice is that we have to pay careful attention to the type of conversations we enter into with research participants in order to distinguish research conversations from supervision and therapy conversations. Although there is a great deal of overlap and convergence between these conversations, I think it would be a mistake to conflate all three. It is important

because I don't think researchers have a mandate to engage in research conversations that act as therapeutic or supervision conversations unless prior consent is given. Finally, an unexpected outcome of participating in this research has been the realisation that I was also changed (re-storied) in the act of engaging in a decentred research practice.

CHAPTER TWO: LITERATURE REVIEW

Life consists of retellings.
Bruner, E. "Ethnography as Narrative"

1.   Introduction

During my initial reading of the literature I discovered that one of the significant findings of therapy process research was that clients and therapists experience therapy differently (McLeod, 1990, page 77). What the client sees as important might go unnoticed by the therapist and the therapist's insightful interpretation might be completely lost on the client. I therefore became interested in the question, what can therapists learn from reflecting on their own *and* their client's experience of therapy?

In this chapter I locate the history behind this question within a body of research literature which explores both the client's and the therapist's experience of therapy. I begin the chapter by discussing the relevance of Bruner's (1986) distinction between paradigmatic and narrative ways of knowing. Bruner's work is concerned to legitimise non-paradigmatic ways of knowing the world. Following Bruner I am not attempting to discredit paradigmatic or methodical ways of researching the world, but rather, to argue against the monopoly claims made on knowledge by this tradition. As will become clearer in chapter three, this dissertation seeks to locate itself in the narrative mode of knowing.

I begin my discussion of the narrative mode of knowing with the case histories of

Sigmund Freud. Although Freud wrote up his case histories in narrative form, he

was, by training, a medical doctor working within a professional culture which

aspired to legitimacy as a natural science. He therefore located his psychoanalytic

investigations within the natural science model of his time. Freud would have

regarded patient self-reports of their experience of therapy as unreliable in

accordance with the psychoanalytic theory of the defended subject. This was copied

by Freud's followers, thereby inaugurating a long-standing tradition of therapist-

centred writing, in which the experience of the patient remained subordinated in

therapy research and clinical papers by therapist-constructed narratives. These

'objective' narratives inevitably made no reference to what the client thought about

the process of therapy! The experience of the client, *as someone who had knowledge*

about what was a helpful or unhelpful to therapeutic practice, was therefore

effectively excluded.

There are a number of other reasons why research into the client's experience of

therapy has been a relatively recent development (McLeod, 1990; Rennie, 1992). To

begin with, experience is itself a slippery concept. I therefore review the complex

relationship between experience and the expression of experience, drawing

especially from anthropological theory. Secondly, the classical social sciences, such

as sociology, "took it as axiomatic" that ordinary folk "could not know their social

worlds as well as researchers" (Bloor, 1997, page 48). Finally, researching clients'

experience raised ethical questions. For example, issues around confidentiality and

the potential harmful impact upon the client's experience of therapy. However, with

the growth of experiential, collaborative and narrative based therapies interest in both

the client and therapist's experience of therapy has steadily found its way into the journals. I review this research literature that deals with the lived experience of therapy reported by both clients and therapists. In particular, I follow the research trail into family therapy and reflecting teams and I conclude with a definition of what constitutes my research problem.

2.   Research into Individual Therapy

2.1   The Paradigmatic and Narrative Modes

Bruner argues that there are two "modes of thought, each providing distinctive ways of ordering experience, of constructing reality. The two (though complementary) are irreducible to one another" (1986, page 11). Bruner names these two modes as the "paradigmatic" and "narrative". The paradigmatic mode is concerned "with the epistemological question of how to know truth" which is contrasted with the narrative concern with "how do we endow experience with meaning" (Bruner, 1986, page 12).

The paradigmatic or logico-scientific mode:

> attempts to fulfil the ideal of a formal, mathematical system of description and explanation ... [it] ... deals in general causes, and in their establishment, and makes use of procedures to assure verifiable reference and to test for empirical truth.

On the other hand:

The imaginative application of the narrative mode leads instead to good

stories, gripping drama, believable (though not necessarily 'true') historical

accounts. It deals in human or human-like intention and action and the

vicissitudes and consequences that mark their course (Bruner, 1986, page 12-

13).

Bruner argues that we know a lot about how to do good science but "precious little in

any formal sense about how to make good stories" (1986, page 14).

From my reading, I came to understand both the narrative mode and paradigmatic

modes of knowledge as arising out of the *sensus communis*, i.e., our common-sense

understandings of lived experience distributed throughout the community (Gadamer,

2001 [1975]). All scientific thinking, as well as narrative thinking therefore shares

common roots in common-sense thinking (Bloor, 1997, page 41). However, the

paradigmatic mode was successful in distinguishing itself from the narrative mode by

establishing a foundation for knowledge based upon scientific method, thereby

seeking to claim a monopoly on truth. Following the Enlightenment period in

western history, the paradigmatic mode has enjoyed unprecedented dominance as the

mode of explaining the natural world. The authority of the class of scientific experts

came to replace the previous authority wielded by the priestly class. The success of

the paradigmatic mode in the natural world also led to its establishment as the ideal

to aim for in understanding the socio-cultural world (Gadamer, 2001 [1975]).

The advocates of paradigmatic knowledge de-graded the narrative mode of knowing

labelling it as subjective and lacking in reliable foundations (Descartes, 1968). The

community continued to tell their stories, but slowly the knowledge (language; ways of talking) of the scientific class began to colonise the lifeworld of the community (Habermas, 1984).

Both modes of knowing offered differing conceptions of the criteria to be used for evaluating knowledge. The paradigmatic mode stressed the criteria to be used to assess the truthfulness of an argument – was the argument valid? Were the observation statements reliable? The narrative mode stressed verisimilitude and aesthetic impact. However, because of the dominance of the paradigmatic mode it has until recently been seen as the only legitimate way to make knowledge claims in academic discourse. During the nineteen sixties and seventies this dominance was challenged, and an "interpretive turn" occurred in the human sciences that began to argue for the legitimacy of alternatives to the paradigmatic mode. This challenge is still being played out today, in such fields as psychology and psychiatry, in the ongoing struggle of qualitative research located in the narrative mode to obtain legitimacy.[2]

Narrative modes of thinking have difficulty establishing legitimacy because they cannot be judged by the same paradigmatic definitions of validity and reliability.

> In the history of psychotherapy process research and of psychology generally, the paradigmatic approach has prevailed; the use of the narrative approach is relatively new and comparatively untried. Yet its major appeal is that it inherently addresses meaning and is thus in principle more suitable as a way

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[2] It would be a mistake in my view to equate qualitative methodology and the narrative mode of thought. Much qualitative methodology seems to me to be paradigmatic in intent.

of understanding the psychotherapeutic process ... (Rennie & Toukamanian, 1992, page 235).

Therefore, research that locates itself in the narrative mode needs to be evaluated by a different logic of justification to that established in paradigmatic research. My discussion of an alternative approach to the validity and reliability criteria established in the paradigmatic mode takes place at the end of chapter three.

The narrative mode of knowing intuitively appealed to me as my preferred way of understanding client and therapist experience of the therapy process. I was interested in the meanings clients and therapists gave to their experience. It was not limited by the strict methodological requirements of the paradigmatic mode and it seemed the best way of exploring subjective experience. It appealed to me because it is a mode of knowing that is more accessible to both the client and therapist and therefore more egalitarian. It did not require special training in order to understand its significance. I wanted to maintain the original language of the therapists' and their clients and did not want to impose by own interpretations of their stories. It interested me that the founder of modern psychotherapy, Sigmund Freud, presented his evidence for the effectiveness of his new therapy in the form of narrative case histories.

2.2   *Freud's Case Histories*

Although Rennie (1992, page 235) describes the application of the narrative approach as "relatively new and comparatively untried" to therapy process research, I traced the tradition back to Sigmund Freud's re-telling the story of the patient's "analysis" from the perspective of the analyst.   The psychoanalytic case histories

written by Sigmund Freud can be read as the "classics" of therapy research. Although Freud never won the Nobel Prize for science he did have the distinction of winning the Goethe prize for literature, in recognition of his narrative accounts of therapy. I think Freud's narrative accounts of his therapy represent the beginning of an attempt to do therapy process research , although it is still the case that Freud's contribution to qualitative research goes unacknowledged in academic texts (Kvale, 1999). It is an interesting feature of Freud's work, that although he understands psychoanalysis as a natural or paradigmatic science, concerned with uncovering the laws of the unconscious, his actual practice can be argued to be that of a hermeneutic or narrative science.[3]

Freud's case histories were constructed from his notes that he would record during the evening following his day's work, adhering as close as possible to his recollections of the patient' own words, including sometimes reconstructing fragments of the therapeutic conversation. Freud thought that to take notes during a session was bad practice because "the consequent withdrawal of the physician's attention does the patient more harm than can be made up for by any increase in accuracy that may be achieved in the reproduction of his case history" (Freud, 1955 [1909], fn, page 159).[4] Kvale (1999) puts forward the case that psychoanalytic interviews (or therapeutic conversations) are examples of qualitative research interviews. Freud's case notes can therefore be seen as his recordings of his "research" interviews. Following the standard qualitative method, after the

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[3] See Ricoeur's book, Freud and Philosophy (1970) for an interesting example of this reading of Freud.
[4] I find this an interesting observation which I believe is a conclusion arrived at by centring the "therapist's attention" as a key factor in good therapy. How interesting to contrast Freud's position with narrative therapists who stress the importance of taking verbatim notes in therapy in order to capture the client's skills and knowledge and how much clients value this practice (White & Epston, 1990).

qualitative interview has been documented, the interviewer then conducts an analysis. Freud does not question the reliability of his memory in the process of transcribing the therapeutic conversation into its representation as written text. Nor does he discuss the question of the validity of his interpretations. Some contemporary analysts argue:

> ... psychoanalytic case studies are interpretative procedures throughout, the validity of their results is evaluated in light of distinctively hermeneutic criteria. These criteria include the logical coherence of the argument, the comprehensiveness of the explanation, the consistency of the interpretations with accepted psychological knowledge, and the aesthetic beauty of the analysis in disclosing previously hidden patterns of order in the material being investigated (Stolorow, Atwood & Brandschaft, 1994, page 19).

However, it remains debatable as to whether these criteria represent adequate justifications for Freud's findings.

Freud wrote his case histories from the perspective of the omniscient narrator (Bruner, 1987, page 21). It is the therapist (detective genre) rather than the patient who is the hero in his therapy tales. This in turn reflected Freud's commitment to a "hierarchically ordered two reality view" in which "one reality is experienced by the patient and the other, known to be more objectively true, by the analyst" (Lee & Martin, 1991, page 224). From this perspective, patient reports could not be trusted because they would be imbued with fantasy, transference, projections and other defence mechanisms (McLeod, 1990, page 2). Freud does not disclose his personal

doubts or admit to mistakes. Although he does raise the issue of what he came to call counter-transference, which he initially saw as being a corrupting influence, in terms of a negative reaction to the patient's transference.[5]

Freud believed he had discovered scientific evidence for the effectiveness of psychoanalysis. (In his later years he was not so optimistic.) In 1901 Freud published *The Interpretation of Dreams,* in which he set out to explain his new discovery: a scientific method of interpreting dreams and symptoms (Freud, 1901 [1950]). In his case histories Freud developed a historical reconstruction of the patient's biography, up to and including the patient's present life situation based upon his interpretations of the meanings of dreams and symptoms. Through interpreting these meanings back to the patient, the analytic cure was engendered through the patient's enhanced self-understanding following the completion of the analysis: symptoms disappeared or were ameliorated. Freud believed that the analyst's reconstruction was an accurate representation of the past.[6] It was an historical truth. On the other hand, the patient's voice was often relegated to the Freudian concept of fantasy. That is, it was accorded less truth value that the analyst's reconstruction. The most important issue in this regard was the disservice that Freud dealt to people who said they had been sexually abused. His reconstruction was that it was a product of a libidinous fantasy for the parent of the opposite sex. As it turns out, what the patients were saying was probably true, and Freud's reconstruction was the fantasy.

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[5] Later developments in psychoanalysis came to understand counter-transference as a source of information about the patient's unconscious communications.

[6] It could also be argued that it was the re-construction process itself (rather than whether or not it was historically "true") that was therapeutic in its effects.

The different experience of patient and therapist is illustrated in the case of the 'Wolf Man', the pseudonym given to one of Freud's patients, Dr. Serge Pankejeff. After many years of analysis Dr Pankejeff finally refused to accept a ban on speaking freely by giving an interview to Karin Oberholzer (1982). Epston (1998, page 57) comments "for the first time the 'other' speaks back as a person rather than as a case study":

> **SP**: In my story, what was explained by the dreams? Nothing, as far as I can see. Freud traces everything back to the primal scene which he derives from the dream. But that scene does not occur in the dream. When he interprets the white wolves as nightshirts or something like that, for example, linen sheets or clothes, that's somehow far-fetched, I think. That scene in the dream where the windows open and so on and the wolves are sitting there, and his interpretation. I don't know, those things are miles apart. It's terribly far-fetched (Oberholzer, 1982, page 35).

Alternative readings of Freud's relationship with Serge Pankejeff are available. Gardiner (1971) emphasises how Dr Pankejeff cooperated actively in the construction and follow-up of his own case, and how Freud "took up a collection every spring for six years so that the Wolf Man could pay his wife's hospital bills and take a vacation" (quoted in Lee & Martin, 1991, page 253).

Many commentators have since critiqued psychoanalysis on the understanding that psychoanalysis claims to be a paradigmatic science. Although psychoanalysis has had an enormous influence on various academic disciplines and popular culture, it

has failed to establish itself in the academy as a *psychological* science because of this reason. A classic example of these critiques was the one developed by Karl Popper (1966) in his book *The Open Society and its Enemies*. He argued that psychoanalysis was not a science because it did not satisfy the criteria of falsifiability. Of course, Popper was operating on the assumption that psychoanalysis claimed to be a paradigmatic science. Paul Ricoeur (1970) argued that Freud confused his own hermeneutical or narrative understanding of psychoanalytic method with an attempt to found psychoanalysis as a branch of natural science.

It now seems to be accepted that psychoanalysis is more akin to a hermeneutic or narrative science, and has more in common with history and literature than it does with biology. The central method by which psychoanalytic knowledge is advanced will remain the case study (Stolorow, Atwood & Brandchaft, 1994, page 17). However, even if the psychoanalytic interview and case study are taken as examples of hermeneutic or qualitative research, it is debatable if the findings can be seen as justified. The contrast between client and therapist's stories of their experience illustrates this problem clearly. Hence practitioner-researchers have explored alternative research strategies to investigate the process of therapy.

Given that I was interested in understanding client and therapist experience of the therapy process it soon became clear to me that I had to define what I meant by experience. I also thought this would help to justify my decision to adopt a decentred research practice. I agreed with McLeod (1990, page 73), that a weakness of existing research into client and therapist experience of therapy "has been that it

has not employed any kind of consistent definition or conceptualisation of what is meant by 'experience'."

2.3   *Experience and Experiencing*

At the outset of my research journey, I became interested in the question, what is experience? It is an important question, given that I claimed to be studying client and therapist experience of therapy. The understanding of experience developed in this section, and in the work of other qualitative researchers, has a common source in the German thinker Wilhelm Dilthey (1976). Dilthey was a historian who emphasised the central importance of attempting to understand the subjectivity of persons as agents. In the interpretive human science tradition developed by Dilthey, and expanded by Weber and Schutz, social phenomena are understood to be intentional action as contrasted with behaviour. Human beings are social actors. Action in this sense refers to both internal (mental) and external action. For Dilthey, the essential constituting feature of human experience is time: we organise our experience along a continuum of a past, present and future. Explanations of human action are to be found in the "reasons" (or narratives) people give for their actions.

In the German language, the word for experience, *erlebnis* is taken to mean "a lived through, conscious state" which is normally translated into English as "lived experience". An experience is an event that lives on in our memory. It has significance for us. I contrasted this with what Hobson calls *experiencing*:

> "*Experiencing* is the sense of my state of being, my existence, of 'how I am now'. At this moment. It is prior to the formation of any distinct

conceptions. It is 'felt' from 'within' my body as happening *now*, but as moving, 'flowing' into the future. Ultimately it is indescribable, and can only be intimated in so far as it is expressed in more or less formulated *experiences* which emerge from the steam of experiencing (Hobson, R.F., 1985, page 189).

In this sense, the present moment can never be represented by words because by the time a thought is expressed the present moment has already passed. What was present is already in the past. When we attempt to give voice to our inner experience we are always constrained by the language we are born into. As Wittgenstein argued, our private experience is always expressed in a public language (Wittgenstein, 1953). From my reading of Gadamer I came to understand that lived experience (or historical consciousness) is always already mediated by the cultural, historical and interpersonal situation we always find ourselves situated within. When we come to speak and reflect on our inner experience we enter into discourse which structures our experiences within the collective stock of cultural and historical meanings that are available to us (Berger & Luckmann, 1966). Experienced events are plotted into a story. In contrast to this, we can never represent the world as directly experienced in the present moment because this is prior to language. The world of lived experience as expressed is therefore always reflexive:

We can have an experience, but we cannot have a behaviour... It is not customary to say, 'Let me tell you about my behaviour'; rather, we tell about experiences, which include not only actions and feelings but also reflections about those actions and feelings. The distinguishing criterion is that the

communication of experience tends to be self-referential (Turner & Bruner, 1986, page 5).

Experience is lacking in meaning until the experience itself is "lifted out of the stream of duration" and by the process of reflection, given meaning (Schutz, 1972 [1932], page xxiii). Thus, when experience is given meaning and positioned within a narrative, it is the associated meanings the person derives from the narrative rather than the experience itself, that creates new meanings. Hence the meanings we give to our experience are always open to revision.

Following the phenomenological-hermeneutical tradition, I came to define lived experience to mean salient events in life; events that stood out to the person who experienced them and that were worthy of remembering and reflecting on. This led me to realise that my study, as with most studies based upon qualitative interviews, was asking people to remember their *past* experience of therapy. It followed that each telling of the past is unique, and may have been quite different on a different day or place. I concluded, therefore, that I was studying people's stories about their experience of therapy, as told to a particular audience (me) on a particular day. I was studying what people recalled as significant or meaningful *to them*. This dissertation is therefore a study of how people *re-present* their experience of therapy on a particular day to a particular audience. Similarly, by inviting my co-researchers to reflect on their experience of past events, I was at the same time responsible for creating a conversation that would generate a new experience for them (and for me, as a research consultant engaged in dialogue) as they articulated unique narratives of

their experience of therapy. It is this world of lived experience that is the general focus of my research.

2.4   *Client Experience of Therapy*

In their reviews of the research literature in regard to client experience of therapy, both McLeod (1990) and Elliot and James (1989) identify some common themes and what I have called, a "meta-narrative" of what clients commonly experience in therapy. My reading of this literature, which I summarise in this section, shaped both the structuring of my data production and data analysis.

McLeod (1990) writes that the earliest studies of client experience were carried out by Rogers and his colleagues at the University of Chicago in the late 1940s. "In this research, clients of client-centred counselling wrote accounts of their experiences after the termination of counselling, or kept journal records during counselling" (page 3). The first significant research to use the qualitative interview method to study client experience was conducted by Mayer and Timms (1970). They interviewed sixty-one clients who had received counselling, and stimulated a lot of interest, "partly because of the sometimes *dramatic disjunction between client and counsellor expectations and assumptions* which were revealed, and partly because it demonstrated that research on clients conducted by 'outsiders' was feasible" (page 3). Other significant qualitative interview studies of client experience include Maluccio, (1979) and Oldfield (1983). MacLeod also includes in his review the Interpersonal Process Recall (IPR) method utilised by Elliot and Rennie, whom I will be reviewing in more detail below. He also mentions the work of Orlinsky and Howard, who developed a questionnaire to measure clients' experience of therapy

(1986). On the basis of his review of these studies MacLeod develops a meta-narrative of a typical client's experience of therapy. He does this by identifying "themes and observations" from across these studies and by following the exemplar narrative of a client's experience of therapy as developed by Maluccio (1979). He divides the meta-narrative into three phases: becoming a client, the middle phase and ending. This meta-narrative, as told in McLeod (1990, pages 5-19) will now be summarised in more detail below, because of the influence this meta-narrative had upon my research design. It also reminded me of the "rite of passage" metaphor for therapy (White & Epston, 1990, page 7). The first phase is the separation phase, in which the person enters therapy and takes on the role of 'client' or 'patient'. The second is the middle (or liminal phase), the "betwixt and between" time, where the process of transformation takes hold leading to the final "reincorporation" phase which signals arrival at a new status or identity and the dissolution of the problem that brought the person into therapy in the first place.

Becoming a Client

The formation process of becoming a client begins before contacting the agency and meeting with the therapist. A person's experience of therapy is shaped by cultural expressions of what constitutes a 'client' and a 'therapist'. It is still not unusual in Australia for clients to feel inhibited or embarrassed about attending therapy. It seems to be an acknowledgement of failure, that the person can not solve their own problems. Clients often report feeling anxious, tense or nervous. Cultural context also shapes people's expectations of therapy, as well as clients' previous experience of therapy. Clients are usually evaluating therapists at a first session as much as therapists are assessing clients. Client expectations may effect their evaluation of the

therapist. For example, one can imagine some clients who may see their child as the problem and be expecting a psychiatric diagnosis and expert recommendations on how to 'fix' the child. These expectations may not be met if the theoretical orientation of the therapist is antithetical to this way of working leading to a possible disjunction in the therapeutic relationship. The client's experience of therapy may also change their pre-understandings of therapy. For example, if the therapist in the above example can incorporate the client's expectations without necessarily meeting them and the client's experience of therapy is satisfactory, then they may come to have a different experience to that which they were expecting. This process comes close to the meaning of transference in contemporary analytic practice, were transference is defined as "referring to the ways in which the patient organizes his experience of the analytic relationship" (Stolorow et al., 1994, page 37).

According to McLeod's summation, the conclusion of this first phase is marked by two processes. Firstly, by the formation of a formal or informal contract, detailing problems to be worked on, frequency of sessions and some preliminary understanding of how and when therapy will end. The second process, occurring in parallel with the first, has to do with the establishment of the therapeutic relationship. The client needs to feel understood or empathised with by the therapist. The phase of becoming a client can be said to have come to end with the establishment of a therapeutic alliance: i.e., a therapeutic contract and a therapeutic relationship have both been successfully formed.

The Middle Phase

McLeod (1990a, page 10) identifies three key aspects of the client's experience of therapy following the successful completion of the first phase. These are the experience of self, the experience of the therapeutic relationship and the experience of significant or helpful events.

The Experience of Self

In this section McLeod draws extensively upon the work of David Rennie, a passionate advocate for the importance of studying client experience:

> Therapy can be seen as a service and clients as the consumers of it. It maybe assumed that the clients are capable of offering authoritative opinions on the nature of the service (Rennie, 1990, page 240).

David Rennie is a practising psychotherapist in the person-centred tradition and an academic located in a psychology department. Rennie's research seeks to understand the client's experience of therapy, without placing any prior parameters around it. The purpose of this open-ended approach is to understand their experience regardless of the nature of that experience (Rennie & Toukamanian, 1990, page 236).

Rennie's core findings have to do with the client's sense of self, more specifically, self-awareness, agency, and self-transformation. Rennie's application of grounded theory to his data concluded with "client reflexivity" as the most generic category to account for client experience. Rennie defined client reflexivity as "the client's self-awareness and agency with the self-awareness" (1990, page 247). The finding of

client reflexivity was followed in importance by the client's relationship with personal meaning: i.e., the client's reflection on cognitive/affective processes; train of thought; narratives; insight and contact with feelings. This was followed by the client's defensiveness against self-awareness and resistance to change. One of the implications of Rennie's research is that:

> . . . much of what is salient for the client is covertly experienced. This being the case, we have to be leery of localizing evaluations of therapy in the verbal discourse alone. In order to get a more complete picture, discourse analysts need to access the reflexivity of both the client and the therapist (Rennie, 1990, page 170).

By this quote, I take it that he is suggesting that analysing the transcript of the therapeutic interview is not enough, because this does not give the researcher access to the client's covert experiences, that is, those experiences that the client may feel inhibited from speaking freely to the therapist about. Rennie names this phenomenon, client *deference*. He argues therefore that a discourse analysis of a therapeutic interview would need to be supplemented by a research interview with the client if these client experiences are to be adequately understood.

A general finding from Rennie's research is that most of the problems or issues discussed by clients concerned their sense of self. They had an awareness of "tracking" certain themes in relation to self throughout the middle course of therapy. This leads to a sense of self-transformation:

Thus, the experience of self in the middle phase of counselling is characterised by exploration, discovery and change, and a rhythm of immersion in self followed by reflection. All this is, of course, taking place within the context of a relationship with a helper, and is dependent on the quality of that relationship (McLeod, 1990, page 12).

Which leads into the next theme discovered from the literature reviews: the experience of the therapeutic relationship.

The Experience of the Relationship

The importance of the therapeutic relationship to the success of therapy has been a common finding in both outcome and process research, especially the sense of being understood (or misunderstood) by the therapist. This was Rennie's second key finding. Rennie described the importance to the client of their perception of their relationship with the therapist: that is to say, their feelings about the therapist; balance of power; concern for the therapist; client's perceptions of therapeutic tasks; client's dependence-independence; and the therapist's manner. Rennie's discussion of the phenomenon known as "client deference" relates intimately to the relationship context. This is when a client wants to impress the therapist, and may often hide feelings and thoughts in order to do this. Rennie (1992) refers to this as the "politics of the therapy relationship". There is quite clearly a power imbalance in the therapist – client relationship. An issue that has been central to narrative therapy and the move to de-centre the authority of the therapist through the use of reflecting teams is a good example of this (White, 1997; Hoffman, 2002). Rennie's finding that clients

are reluctant to disclose their disenchantment with the therapy process to the therapist is a point which bears not only on evaluation but also on research.

The Experience of Outcomes

The third key finding of Rennie's research related to the client's awareness of outcomes: by which he refers to the impact of the therapy; the effectiveness of the therapeutic relationship and interventions; the impact of the inquiry interview; and the different or enriched view of the therapy session as a result of the research interview. Change process research has tended to focus on the client's awareness of outcomes, on the question, what does the client experience as "helpful or as hindering"? This is the search to identify therapeutic techniques that work. The work of Robert Elliot and colleagues (Elliot, 1985; 1986; Elliot & Shapiro 1988; 1992; Elliot & James 1989) has made a significant contribution in this area.

Like David Rennie, Robert Elliot is a practising psychotherapist in the person-centred experiential tradition, as well as being an academic located in a psychology department. He specialises in "change process" research. Change process research has been defined as:

> ... the study of the interaction between the patient and therapist systems. The goal of change process research is to identify the patterns and mechanisms of change in the interaction between these systems (Greenberg & Pinsof, 1986, page vii).

Change process research focuses on the connection between therapy process and outcome (Elliot, 1995, page 54). The therapeutic process is studied in order to discover how therapy works to facilitate change. Elliot's work is based on the paradigmatic mode of knowing which assumes that regularities can be discovered, leading to improvements in psychotherapy practice. For example, through studying in detail a number of case studies, key "change events" can be identified and named. It is hoped that other therapists will be able to replicate these change events in the future. Elliot and colleagues have been conducting quantitative and qualitative research into the experience of clients and therapists of the change process for over twenty years. His work has become known as the "events paradigm".

Elliot and colleagues have identified two key categories: task change events and relationship change events (Elliot & James, 1989). The "task" change events were: (1) the development of a *new perspective* leading to increased insight or awareness of something new; (2) making progress towards solving the presenting problem; (3) clarifying the problem by, for example, arriving at a clearer definition; and (4) bringing the focus of attention on topics the clients may have been avoiding. The "relational" change events were: (1) the experience feeling understood; (2) clients becoming engaged or involved in the helping process; (3) feeling emotionally supported or reassured by the counsellor; and (4) having an experience of personal connection or contact with the counsellor.

A shared finding of Rennie and Elliot's work is the significant relationship between the client's perception of the therapeutic relationship and their perception of therapeutic outcomes. A positive experience of the relationship tended to correlate

with a positive experience of outcomes. I was curious if this would also be an important factor for clients working with a reflecting team.

2.5   *Therapist Experience of Therapy*

Research into the therapist's experience of therapy is a recent development: "the experience of the counsellor or psychotherapist is not a topic which has received very much systematic investigation" (McLeod, 1990b, page 66). One of the reasons given by McLeod above is that therapists find it difficult to put their experience of the therapy hour into words. This seems strange given the training therapists' receive in helping clients' put their experience into words. However, in reality, therapists often do not give themselves time to reflect on their experience. This is a great loss, because the practice wisdom of practitioners is often not recorded, and research is then left to academics. This dissertation is one attempt to fill in this gap and explore researcher- practitioner partnerships as a means towards correcting this waste of experience.

This lack of research is also curious given that research shows that the experienced therapist relies upon their moment-by-moment experience of the therapeutic session to guide their moment by moment response to their client(s). For example, there have been some interesting textual analyses of excerpts from session transcripts, highlighting the "micro-process" of conversational moves and the therapeutic agendas of therapists (Kogan & Gale, 1997). Interpersonal process recall is also being utilised to gain access to the thoughts and feelings of therapists (and clients) on significant events in therapy sessions (Elliot & Shapiro, 1988 & 1992).

In McLeod's review of this area (1990, page 68) he observes that the most popular research method for studying therapist experience has been the rating scale, in particular the Orlinsky and Howard's Therapy Session Report questionnaire (Orlinsky & Howard, 1977; 1986), Stiles (1980) and the Session Evaluation questionnaire (Stiles & Snow, 1984). Rating scales are popular because they can be analysed using standard statistical tests but the main disadvantage is that they also standardise subjective experience. To overcome this problem open-ended questionnaires have been used where therapists write their own words about their experience. More recently, Interpersonal Process Recording has been used by researchers to interview therapists about their experience of the session while watching a video tape of the session (Elliot, 1986). Finally, interviews have been used to explore various aspects of therapists' experience (Dryden, 1985; Maluccio, 1979).

According to McLeod (1990, page 73), the limited amount of research so far has focused on two aspects of the therapist's experience: varieties of feelings and behaviours and more specifically, types of difficulty or dilemma which therapists encounter in their work. This study seeks to expand on this base by investigating how therapists experience their use of self, their relationship with their client/s and their understanding of helpful or hindering events in a therapy session. It also seeks to combine research into client and therapist experience, in the hope that it will be able to shed some light on the degree to which these experiences may differ and how they may mutually influence each other.

3.   Reflecting Teams

Reflecting team techniques and processes have been adapted by family therapy practitioners around the world. This section provides a brief introduction to the history of the development of reflecting teams, which has been well documented previously (Anderson, 1987, 1992, 1999; Perlesz et al., 1994) followed by a small sample of some of the research into reflecting teams, which has steadily grown over the last 20 years (Sells, et al., 1994; 1996; Smith, et al., 1993; 1994). Reflecting teams embody the principles of "second order" family therapy (Perlesz, et al., 1994). The term "second order" was imported into family therapy from the field of cybernetics research. In first order cybernetics the observing system was seen as being outside or separate from the observed system. In second order cybernetics the observing system is included within the system. There is no objective or neutral point outside of the system:

> … while cybernetics had originally been concerned with circular
> relationships in systems that could be observed, it has recently focused on
> applying cybernetic principles to the understanding and language of
> cybernetics itself – the cybernetics of cybernetics, or *second order*
> cybernetics. Thus, this second order cybernetics deals with observing, rather
> than merely observed, systems. (Steier, 1991, page 3).

In first order family therapy, one-way screens were used to train therapists who observed the therapy session from behind the screen. The early use of the one-way screen in family therapy reinforced the notion of a hierarchically ordered view of

reality in much the same way as did Freud. The index (interviewing) therapist would take a break and have a private consultation with the team behind the screen, and then return to the family to deliver an intervention informed by the team. However, when a team of family therapists based in Milan started using a questioning process known as circular questioning (in which family members were asked to comment on the feelings and behaviour of other family members), it was discovered that the questions themselves generated change, without the need for a formal intervention at the end. The work of Karl Tomm (1984ab; 1987ab; 1988) details the evolution of the Milan team from a strategic or instrumental approach to an approach based upon the use of reflexive questions. The work of the Milan team paved the way towards a more reflexive and less hierarchical form of therapy, in which curiosity and circular questioning replaced therapist knowledge of family functioning as the primary form of intervention (Andersen, 1987; 1992). This became known as the reflexive turn in family therapy, in which the therapist system could no longer be seen as neutral or separate from the family system. The two systems were joined. Then "by accident one day" a team of therapist in Norway happened "to reverse light and sound" so that the family observed the conversation between the interviewing therapist and the team, and the "reflecting team" was born (Anderson, 1999). The observers became the observed. Anderson noted how this changed the content and tone of the conversation and how families appreciated the opportunity to listen to the therapists talking among themselves. The outcome was that team reflections often had a powerful transformative effect on families. They also had the effect of changing the way in which therapists discussed clients. Relationship and conversation became the new metaphors from which to understand therapy. Clients' problems were

understood to be transformed through participating in *therapeutic conversations within the context of a respectful and equalitarian relationship:*

> I felt increasingly uncomfortable with acting as if I knew better than our clients what we should talk about, how we should talk, what they should understand and even what they should do (Andersen, 1992, page 89).

Therapists no longer positioned themselves at the centre as experts on a client's internal states, family dynamics, or structure. Rather they used their conversational skills to engage the family in generating a conversational "context for change" (Perlesz, *et al.*, 1994). It was agreed that therapists could no longer speak from a position of authority on peoples' lives. Therapists also tended to stay as close as possible to the language spoken by clients, rather than introduce professional language. Their way of talk changed. Reflecting team processes are now seen as congruent with a more egalitarian form of therapy (Hoffman, 2002). For example, White (1997) developed a critique of the politics of professional practice and proposed an ethic of collaboration and decentred practice as alternative. White argued that the intention of therapeutic conversations is to bring forth the knowledge of the client rather than the therapist. According to White, the expertise of the therapist is located in how they conduct the therapeutic conversation. Similarly, the purpose of the reflecting team process is to amplify the knowledge and skills of the client. Not only was the reflecting team a therapeutic innovation but it also lent itself as a vehicle for expanding the scope of training and supervision practice. Teams are now used extensively in family therapy training centres and conferences for

involving audiences directly in the process of therapy. They have also been put to good use in supervision (Lowe & Guy, 1997; Fox et al., 2002).

Given the extent of this diversification of practice, it is not surprising that a number of differences have now emerged in reflecting team practice. In order to understand these, a distinction can be made between the reflecting team technique (RTT) and the reflecting team process (RTP):

> The R.T.T. refers to the *technique* whereby a team of observing therapists present their views about the therapy process, problems or solutions, to observing family members and the therapist at selected moments during the therapy. The R.T.P., on the other hand, refers to an *overall therapeutic process*, whereby the guiding principles used when making reflections are applied, not just during the moment of reflecting in front of the family and therapist, but at all moments of therapy and team discussion ... the R.T.T. is simply a therapeutic strategy, method, style of practice or way of working with families and teams that could arise from a variety of theoretical and practice orientations ... The R.T.P., however, refers to an overall attitude towards therapy, and a way of thinking about thinking about therapy, and thinking about doing therapy (Perlesz *et al.*, 1994, page 119).

This has meant that although reflecting team techniques have been duplicated in a variety of practice settings, many varieties of refecting team processes have been developed. These can be categorised in terms of *pluralistic* and *theoretically-aligned* reflecting team processes. Theoretically-aligned teams follow for example the

processes of narrative therapy or solution-focused therapy (Lowe & Guy, 1996; White, 1995). For example, White (1997) now refers to reflecting teams as "outsider-witness" groups or practices. Pluralistic teams, as the name implies, can adopt processes from a wide range of practice orientations and psychological theories. The reflecting team process researched in this thesis is an example of a pluralistic approach.

Reflecting team processes are theoretically located in the intellectual traditions of hermeneutics, social constructionism and post-structuralism. A concern with language as a *social* discourse is common to these traditions. In turn, this focus on language, discourse and narrative has inspired couple and family therapy practitioners to start to embrace qualitative research strategies such as ethnography, grounded theory and discourse analysis. Given the shared concern of therapists using reflecting team processes to deconstruct therapist expertise and promote client expertise, research into reflecting teams has been surprisingly slow to develop. The next section details some of the qualitative research into reflecting team process that has begun to appear over the last 15 or so years.

3.1 Research into Reflecting Teams

Prior to the 1990's both outcome and process research into family therapy failed to focus on client experience. Like psychoanalysis before it, when the client's experience of family therapy was discussed, it was mainly from the viewpoint of therapists, researchers and theoreticians (Laszloffy, 2000). Few client-based descriptions of family therapy were available prior to the 1990's and "no direct client commentary on the value of reflecting teams" had yet appeared in articles or books

(Sells et al., 1994). However, following the reflexive turn, practitioner interest in researching client and therapist experience has grown. More contemporary research is based on the premise that "all participants in research are truly co-researchers and collaborators" (Sells, et al., 1994, page 262). Qualitative research into couple and family therapy has now started to regularly appear in the journals and this includes studies evaluating the use of reflecting teams (Gehart, Ratliff & Lyle, 2001, page 261).

A series of recent ethnographic studies have focused on both the client and the therapist's experience of reflecting teams and their perspectives of change over the course of therapy. (Sells et al., 1994; 1996; Smith, et al., 1993; 1994). These studies found that clients gained new perspectives from listened to therapists' reflections. A recurrent finding was the value clients attributed to hearing "multiple perspectives" presented by the reflecting team (Smith, et al., 1993, page 40). Clients commented that they benefited from the presentation of "more opinions, perspectives and commentary" and that the "perspectives from the reflecting team helped them see the problem differently" (Sells et al., page 255).

This common report of seeing problems from a different perspective was helped along by the experience of the distancing effect, when the couples sat back and listened to the problem as it was being discussed by the team. As one client commented:

It is not so personal, when you're sitting back listening to other people talk

about you. It's like you're outside the problem and you can see it differently

(Sells et al., page 261).

This is sometimes referred to as the "fly on the wall" phenomenon (Prest et al.,

1990). Again, this finding was reiterated in the other studies. This supports

Andersen's (1987; 1992) claim that the process of change in reflecting team practice

is dependent upon the family's "ability to hear the same problem in a slightly

different fashion" (Smith et al., 1994, page 268).

The other major finding highlighted by these studies was the importance of the

therapeutic relationship and the personal qualities of the therapist, a topic often

neglected in family therapy. Clients described specific "personal" qualities of the

therapist (as distinguished from professional expertise and manner) as being critical

to successful outcomes. As one client commented:

I think he's real down to earth. I mean you can tell that he really understands,

or he tries to understand where we're coming from. I think that's very

important in a counsellor. That he comes across to the client that he

understands. He is on our level and this makes us feel comfortable. To be

honest with you, if he didn't understand and was sincere, I would not be back

no matter how good his skill (Sells, et al., 1996, page 330).

The therapeutic relationship was therefore crucial to creating a safe environment for

clients, allowing them to be open to different perspectives on problems and therefore

to make changes. The actual technique of keeping strict boundaries between clients and the team seemed to help this process to occur, along with the personal qualities of the therapists.

4. Conclusion: Statement of the Research Problem

In this chapter I argued that the narrative mode of research, with its focus on the meanings people make of their experience, was more suitable to the objectives of my study than the paradigmatic mode. I then argued that Freud was an early pioneer of narrative research but that his methodology was limited by his psychoanalytic theory of the subject and the lack of a clearly argued case for the validity of his findings. In considering how to go about conducting qualitative research into the experience of therapists and clients I became fascinated by the question what do we mean by experience?

Questions of how to study experience are influenced by what we mean by experience. I therefore drew a distinction between 'experience' and 'experiencing'. I defined an 'experience' as being something we can represent and therefore something that has already happened to us; on the other hand, I defined 'experiencing' as being something that happens in the present moment. It is located beyond the realm of discourse. Inevitably when we express our experience our expressions or representations are historically and culturally bound, yet at the same time influenced by the uniqueness of our own biography.

In my review of client and therapist experience of therapy I developed the template that guides and organises my research, based primarily on McLeod's (1990) review

of the literature. This takes as its focus the clients journey through therapy focusing on becoming a client through the middle phase of exploring experience of self, the therapeutic relationship, therapeutic outcomes and endings. This study also seeks to explore the parallel experience of the therapist in the domains of self, experience of the relationship with their client and their experience of therapeutic outcomes.

I concluded with a review of research into reflecting teams. A reflecting team process operates as a therapeutic conversation designed to create new meanings for clients and as an ethical practice seeking to create respectful therapeutic relationships and decentre the authority of the therapist. This dissertation builds on previous research by seeking to explore the question of how clients and therapists experience their participation in a reflecting team process, and in particular, what experiences contributed to beneficial outcomes. This dissertation also follows the lead of other research studies by relating to participants as co-researcher in exploring this question with me. However, I believe this study takes this one step further by inviting the participant therapists into *further* dialogue through a process of reflection on both their own interview transcripts *and* those of their clients.

In exploring this question it was hoped that the research findings would be (1) relevant to practitioners and (2) contribute to the development of our understandings of the transformative effects of reflecting-team processes and the unique organisation of therapeutic relationships within this context.

CHAPTER THREE: DECENTRING RESEARCH PRACTICE

The challenge for therapists is to find research methods that fit with their clinical theories and their goals as clinicians.
Maione, P.V. *"Choice Points: Creating Clinical Qualitative Research Studies"*

1.   Introduction

In this chapter I review how I arrived at a decentred research practice. I begin by telling the story of my search for a method adequate to the task of researching therapy that was congruent with the therapeutic practice of narrative therapy and reflecting teams. I explain how I departed from the methodology developed by David Rennie, a leader in the field of therapy process research. I then locate the idea of decentred research practice in narrative therapy. This is followed by a discussion of the research interview process, including my decision to choose semi-structured research interviews as the primary method of data generation, rather than, for example, a video recall process. I discuss how I linked the themes identified in my literature review, to the construction of the semi-structured interview guide used in the research. I then reflect on the nature of transcripts, participants' reflections on transcripts and the difference between research and therapy interviews/conversations. Finally, I develop some alternative justification principles to the concept of validity, before concluding the chapter with a discussion about how the research conversations came to mirror the structure of a reflecting team conversation.

2. The Search for a Method

Choosing a method was an exploratory process for me and my original research design changed direction a number of times. I began to appreciate some similarities between the role of novelist and researcher:

> An author starting on a novel may have a main plot in mind that will be developed on the way. An interview inquiry, too, may be seen as leading to a story the researcher wants to tell, where the key points he or she want to relate to the readers are kept in mind from the start. In both cases the characters may take on their own life during the writing, developing along lines other than those intended by the author, following a structural logic of their own. The result may be a good story, providing new convincing insights and opening new vistas for understanding the phenomena investigated (Kvale, 1996, page 201).

When designing my research plan, following my immersion in the literature, I was initially overwhelmed by the bewildering array of qualitative methodologies that are available (Denzin & Lincoln, 1994). These differing approaches were also linked to differing philosophies which, as students of qualitative methodology, we were urged to make our acquaintance with (McLeod, 2001). To understand the differing qualitative methods it was necessary to immerse oneself in the particular philosophical tradition they were an expression of. My confusion helped to motivate me to try and make my writing on theory and method clear and understandable. It

also became clear to me that theory and method are linked (McLeod, 2001). My theoretical position therefore needed to be clearly defined and then the choice of method would follow.

I knew I wanted to study the experience of therapy. The study of the experience of therapy can be undertaken in the paradigmatic mode or the narrative mode. Paradigmatic explanations are expected to be founded upon the translation of experience into categories which can then be measured, or observations that be can be observed consistently by researchers external to the therapy process. The proposition that experience can be measured seeks to reduce the uniqueness of subjective meanings into objective variables whose relationships can be quantified. This is so as to conform to the requirement that results need to be able to be replicated by others in order to be considered valid. Although this is one way of representing experience, it suffers from being experience-distant (Kohut, 1959; Geertz, 1973; White, 1997). That is, when experience is measured, for example, reduced to rating scales, the unique richness of subjective experience is lost. Experience is objectified so "that it no longer contains any historical element" (Gadamer, 2001/1975, page 346).

The narrative mode is open to capturing detailed descriptions of these unique experiences. It does not seek to reduce them into units of measurement that can be replicated by others. These experiences are both uniquely individual, relative to the life of the person who experiences it and mediated by the cultural and historical context. However, the attempt to reduce experience to units of measurement

alienates this context and this sense of adventure. I knew therefore I had to find a methodology that fitted the narrative mode of knowing.

The literature also indicated that it was important to be guided by your research question. It was the choice of my research question that in the end, guided my choice of a method. My first attempt at a question, "How do clients experience the process of change in family therapy?" was situated within the tradition of therapy process research. I first considered utilising video recordings of my own therapy sessions, watching them together with my client and then interviewing my clients about their experience of the session. This was something I was already familiar with from my training in narrative therapy (White, 1997, pages 172-190). However, this seemed like dangerous ground for an inexperienced therapy researcher to attempt first off. I was concerned about how I would be able to justify the dual roles, but my major concern was client deference (Rennie, 1994). Would the client be able to speak freely or would they feel constrained from saying anything that might be taken as a criticism? Then, following a - discussion with a friend (also immersed in a qualitative research PhD) I decided do a study of reflecting teams and take on the role of researcher only. Thus the research question became, "How do clients and therapists experience the process of working with a reflecting team?"

It wasn't long before I came under the influence of David Rennie's work and began to consider copying his methodology rather than trying to invent my own. McLeod refers to Rennie's work as "a jewel in the crown of qualitative psychotherapy research" (2001, page 81). Rennie has relied on qualitative methods exclusively and uses an opened ended interview to explore the client's experience. His data

collection methodology relies on Interpersonal Process Recall, or "IPR". IPR is a

technique which uses the replay of either video or audio tape to stimulate the client's

recollection of subjective experience during the therapy conversation. Other than the

instruction to stop the tape when they become aware of something important or

significant, no predetermined focus is imposed on clients when reviewing the tape of

the therapy session. This method gives the client control over the decision as to what

they want to focus on in the recall session (Rennie, 1990, page 155). The open-ended

interview is then recorded. Rennie then applies a grounded theory methodology to

analyse the transcripts. I thought I could strengthen Rennie's approach by

interviewing both the client and the therapist thereby enabling me to compare and

contrast their different perspectives of the same session. This, then, was the plan I put

forward in my original research proposal. I would playback the video of a reflecting

team doing their team reflection and I would follow the work of Rennie in stopping

the tape and interviewing the clients and therapists about their experience. I would

then transcribe these tapes and conduct a grounded theory analysis on the data.

However, as I continued to read the literature I became interested in questions

relating to the clients experience of self and of the therapeutic relationship that could

not be answered from focusing on a single session. Also, a pilot interview that I

conducted with a client utilising IPR method alerted me to the possibility that this

kind of interview might focus clients on the personal issues they were dealing with in

therapy, rather than on their experience of self and their relationship with the

therapists and the therapy practice and outcomes. Other researchers had also

commented on this problem (Gaddis, 2002). So I decided to do a semi-structured

research interview instead. I felt that what I lost perhaps in fine detail, I would gain

through the added distance from the therapy process itself. However, I was still undecided as to how to analyse the data after I had completed the transcripts. Was I still going to do a grounded theory analysis or some other form of textual analysis?

3.   Beyond Method: Towards a Decentred Research Practice

Rennie claims to situate his research in the narrative paradigm and therefore does not seek to identify universal regularities in therapy that can be verified through independent observation, as in the paradigmatic mode. Rennie wants to locate his grounded theory analysis in the broader tradition of hermeneutics (Rennie, 1998; 2000). Rennie acknowledges the influence of constructionist ideas in that the research text is a co-construction or representation of the clients experience jointly produced by the researcher and the client, and that the interpretation of the text will inevitably reflect the pre-understandings of the researcher. However, Rennie argues that the relativism of his hermeneutics is balanced by a commitment to a realist epistemology through the methodical application of grounded theory analysis and the attempt by the researcher to acknowledge and bracket his or her pre-understandings. Rennie therefore justifies his findings exclusively on a grounded theory analysis of the data. He argues for grounded theory to be recognised as a form of applied hermeneutics, which he names "methodical hermeneutics". Rennie claims methodical hermeneutics is a theoretical framework that applies not only to the grounded theory method but to empirical phenomenology, narrative analysis and discourse analysis.

Rennie argues that his methodical hermeneutics develops a bridge between relativism and realism. This is to distinguish it from Gadamer's work *Truth and Method* (2001 [1975]) in which Gadamer distinguishes his philosophical hermeneutics from the methodological hermeneutics of Dilthey. Rennie builds his approach on the work of Dilthey and the pragmatics of Pierce rather than Gadamer. The method is designed to increase the objectivity of the results by reducing the influence of the researcher's bias. However, I remained unconvinced that method (quantifying codes and categories) was the approach that was best suited to my project.

I was initially attracted to Rennie's unique combination of IPR with grounded theory. Grounded theory is one of the most popular and legitimated forms of qualitative data analysis methods, and has been used in a large variety of studies including therapy research. It seemed therefore a safe and reliable option. It shares the classical hermeneutic interpretive principle of the circle, understanding the part in terms of the whole and the whole in terms of the part. It methodically satisfies this criterion by doing an exhaustive constant comparative analysis of the various texts that are to be subjected to an analysis.

Grounded theory was originated by Glaser & Strauss (1967). They were both sociologists trained in the symbolic inter-actionist tradition of the Chicago school. They understood grounded theory to be a method of inductively developing theory on the basis of categories that are "discovered" grounded in the data. The data in grounded theory analysis is often in the form of interview transcripts. The text is broken down initially into descriptive codes corresponding closely with the original

language of the text. The next step is to classify these codes into higher order codes or categories on a more abstract level, making connections and links between the various categories. This process continues until a point of "saturation" is reached and the analysis is left with one master category at the top of the hierarchy. In a grounded theory the objectivity of the analysis rests on the claim that the theory is "accountable to the data" (Rennie, 1998, page 103).

One of the strength's of Rennie's research is that his categories are grounded in the language of the clients, and we are therefore learning from the clients themselves. However, I remained unconvinced that the method employed in grounded theory shielded the analysis from the influence of his own commitment to person-centred therapy and how this may have co-constructed both his and his research subject's experience. In my view, the editorial decisions taken in a grounded theory analysis ultimately rest on the reading or interpretation of the analyst, rather than being somehow "discovered" in the data. However, whatever position one takes on these issues, I believe Rennie's findings are of interest to the practitioner. It appears that there is a lot to be learnt by the therapist focusing singularly on how the client experiences the therapeutic process.

Having eliminated grounded theory my search continued. I read about narrative analysis and discourse analysis but I still felt I was at a crossroad not sure of what direction in which to turn. The turning point came following some conversations in with practitioner-researchers who work in the tradition of narrative therapy (Law, 2000, 2002; Gaddis, 2002). Following these conversations, I realised that I could

develop my own methodology that was congruent with the values and ethics of narrative therapy and reflecting teams.

Narrative therapy was first clearly articulated as a distinct form of therapy practice, in the book *Narrative Means to Therapeutic Ends* (White & Epston, 1990). In this book the authors introduce the idea of the "text analogy" as a means for understanding the social world and as a heuristic metaphor for the practice of therapy:

> This analogy also made it possible to conceive of the evolution of lives and relationships in terms of the reading and writing of texts, insofar as every new reading of a text is a new interpretation of it, and thus a different writing of it (White & Epston, 1990, page. 9).

The text is "performed" by persons when in the process of reading the text they make new interpretations or meanings out of it. When persons make meaning out of the events of their life, they tend to plot them into a story. Each time the story is told meaning is performed. The teller is changed in the telling.

White & Epston (1990) draw upon a reading of Foucault in order to situate the stories that people live by within the social relations of knowledge and power. By doing this they succeed in creating a radical therapy based in philosophy and social theory rather than positivist and biological theory. Following the work of Bruner (1986) they locate narrative therapy "within the context of the narrative mode of thought" as a legitimate *alternative* to the logico-scientific mode of thought. White

(1997) also later incorporated the work of Geertz (1973) preferring the metaphor of "thick" and "thin" descriptions to the metaphor of "surface" and "deep" popularised by the discourse of psychoanalytic psychotherapy. I therefore decided to situate my *research* practice within the following principles:

A therapy (*research practice*)[7] situated within the context of the narrative mode of thought would take the form that:

1. privileges the person's lived experience;

2. encourages a perception of a changing world through the plotting or linking of lived experience through the temporal dimension;

3. invokes the subjunctive mood in the triggering of presuppositions, the establishment of implicit meaning, and in the generation of multiple perspective;

4. encourages polysemy and the use of ordinary, poetic and picturesque language in the description of experience and in the endeavour to construct new stories;

5. invites a reflexive posture and an appreciation of one's participation in interpretive acts;

6. encourages a sense of authorship and re-authorship of one's life and relationships in the telling and retelling of one's story;

7. acknowledges that stories are co-produced and endeavours to establish conditions under which the "subject" becomes the privileged author;

8. consistently inserts pronouns "I" and "you" in the description of events (White & Epston, 1990, page 83).

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[7] My insertion.

A research practice that was located in the narrative mode could follow the above principles and adapt them to research ends (Gaddis, 2002).

Gadamer (2001 [1975]) also draws on the text analogy in his major work *Truth and Method*. Gadamer's hermeneutic philosophy is based upon the analogy between reading a text and participating in a conversation. Both are acts of interpretation:

> The understanding and interpretation of texts is not merely a concern of
> science, but obviously belongs to human experience of the world in general.
> The hermeneutic phenomenon is basically not a problem of method at all. It
> is not concerned with a method of understanding by means of which texts are
> subjected to scientific investigation like all the other objects of experience ...
> yet it too is concerned with knowledge and with truth ... But what kind of
> knowledge and what kind of truth? (Gadamer, 1975/2001, page, xxi).

Gadamer seeks to legitimise the knowledge that he calls "understanding" in a realm that lies outside of the logico-scientific paradigm. He seeks to refute the claims made by science that the only legitimate knowledge is the universal claims of science. This sounds to me very similar to the realm of the narrative mode of thought described by Bruner (1986; 1990). Gadamer states that his investigations are:

> Concerned to seek the experience of truth that transcends the domain of
> scientific method wherever that experience is to be found, and to inquire into

its legitimacy. Hence the human sciences are connected to modes of experience that lie outside science: with the experiences of philosophy, of art, and of history itself. These are all modes of experience in which a truth is communicated that cannot be verified by the methodological means proper to science (Gadamer, 1975/2001, page xxii).

I therefore began to question the claim of Rennie that his work which utilises grounded theory was in fact situated in the narrative mode. I came to the view that grounded theory had more in common with the paradigmatic mode than the narrative mode. I therefore decided to design my research method according to the criteria of narrative therapy and located it in the hermeneutic/narrative mode of thought. I decided to name my approach a decentred research practice (rather than a narrative approach to research) to distinguish it from Rennie's work which also claims to be located in the narrative mode. Decentred research is a form of inquiry conducted in collaboration with conversational participants, in which the findings of the research are arrived at through a combination of dialogue, interpretation and reflexivity rather through the means of a procedural methodology. The goal of a reflexive dialogical approach to research was to decentre the voice of the principal researcher and to document the understandings of the research participants themselves, using their own words. At the same time, I was hopeful that the research interviews would lead to a rich description of the knowledge and skills of the participating therapists.

However, the question that interested me now was, how could I involve the research subjects in the process of interpreting the research texts, in this case, the transcript of the first interviews? The problem as I saw it with most qualitative methods was that

the process of interpretation was always left to the expertise of the principal researcher, thereby privileging the interpretations of this researcher. The problem was not that these were not legitimate and interesting forms of inquiry, only that they tended towards a privileged viewpoint. That is, most research analysis published in journals is based upon analytic tools (discourse analysis; grounded theory) wielded by the principal researcher. This applies even if the research is about client or therapist perspectives.

But what about the research participants themselves? Surely they should be given if not greater then at least equal authority over the interpretation of the text? After all, I was interested in *their* interpretation of their experience. In any case, the analysis of the interview transcript was not about attaining access to some universal reality (essentialism) referred to as the experience of therapy, but rather would be an outcome of the meanings all participants brought to the process. Therefore, rather than relying upon procedural methods to interpret the data, I decided to return to the therapists and to explore with them their interpretations of the transcripts, thereby expanding the richness and variety of textual interpretations. My research question evolved into "What can therapists learn from reflecting on their own and their client's experience?" It would have been equally possible to have invited clients to explore their interpretations also, however my decision not to take this course of action is explained in section 4.6 of this chapter.

It followed that the initial interviews and transcriptions were not the end of the conversation but just the beginning. I was not going to do an analysis of a *static* text, I was going to interact, or enter into, dialogue with the text via the interpretive

perspective of the therapists. I therefore spent many hours listening to and thinking about the research interviews, before re-presenting the research interviews in summary form or in letter form. I also decided to invite the therapists to participate in follow-up interviews focusing on their experience of both doing the interview and *reading the transcript* of their own and their client's interview. I then made another transcription of what I termed the 'second-order' interviews, which eventually became incorporated into the dissertation as the research findings. This was one way of including the voices of the persons who participated in the research as clients or therapists alongside my own in the final part of the dissertation, thereby creating a multi-voiced text.

My search for a method in the end took me beyond procedural method towards a reflexive-dialogical methodology (decentred research practice) which I felt was congruent with the theory and practice of narrative therapy and reflecting teams. Hence, in contrast to Rennie, objectivity was not a concern to my project, given that it is concerned with the generation of local rather than global knowledge. This in turn necessitated a turn towards alternative principles justifying the "findings" of the research other than traditional concepts of validity.

4. Data Production

4.1 Research Interviews and Knowledge Formation

I chose research interviews as my primary research practice because I thought this would give the participants an opportunity to richly describe their lived experience of therapy (Kvale, 1996). The research interview was a natural choice of method for

me because of its similarity to the therapeutic interview. I became interested in how knowledge was produced from a research interview and how much influence the research interviewer had over the production of this knowledge.

Kvale (1996, page 3) introduces two metaphors to describe the work of the interviewer and to illustrate his preferred approach, they are the "miner" and the "traveller". In the miner metaphor, metal stands for the knowledge the miner digs for or uncovers.[8] The "metal" can be paradigmatic observations or narrative units of meaning. During this mining process the nuggets of data unearthed by the miner remain untouched by the miner's tools. They are unearthed in their pure form. The alternative metaphor of a traveller situates the researcher on a journey, wandering through varying conversational landscapes with interesting people along the way. I identified with the traveller metaphor, which influenced my style of presentation: writing about my research "journey" and what I discovered along the way.

> The two metaphors – of the interviewer as a miner or as a traveller- represent different concepts of knowledge formation. Each metaphor stands for alternative genres and has different rules of the game. In a broad sense, the minor metaphor pictures a common understanding in modern social sciences of knowledge as "given". The traveller metaphor refers to a postmodern constructive understanding that involves a conversational approach to social research. The miner metaphor brings interviews into the vicinity of human engineering; the traveller metaphor into the vicinity of the humanities and art (Kvale, 1996, page 4-5).

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[8] In a similar fashion Freud drew extensively on the metaphor of archaeology (same 'family' as miner) to describe the process of uncovering ancient relics buried deep in the unconscious!

The miner seemed to me to correspond to the paradigmatic mode of thought and the traveller to the narrative mode. In particular I saw the traveller metaphor capturing the reflexive, dialogical approach to knowledge formation that I had embraced as my preferred methodology. I therefore understood the decentred research conversation to be a unique conversational genre, distinct from other forms of conversation.

4.2   The Sociocultural Context

I had commenced working at a child & adolescent mental health service, in metropolitan an Australian city in November of 1999. During my stay there I became interested in the work of what was known as the "Friday Team". The team consisted of Andrew Wood, a social worker and family therapist by profession who is also the Regional Director of the agency. Carole Meech, a nurse and child and family therapist by profession and Ros Powry, a child and adolescent consultant psychiatrist. The Friday Team was a 'closed team' and had been working together as a family therapy team for 12 years, which is unusual in itself. During that time they developed a unique team culture which had evolved over the years from a "message delivery" style of work to a "reflecting" style of work. (All members of the team expressed the view that they could never go back to the "old ways" of working again). The team would consult on Friday mornings each week and would on average see two families per morning.

When I decided to focus on reflecting teams the Friday team seemed an ideal choice to work with as co-researchers, given that they had all been involved in collaborative research projects. The team worked broadly within a systemic-narrative therapy

framework and had been particularly influenced by the work of Milton Erickson and Steve de Shazer. They seemed pluralistic in their approach, adopting their style to fit with their clients. We therefore shared an interest in a common approach to therapy.

I also became interested in the effects of my interviewing practice on the participants (Mishler, 1986). The research conversation was a form of conversation where the outcome was a co-production of the interviewer and the interviewee (Kvale, 1996, page xvii), however I had a great deal of influence over how the talk was managed. It was a professional interview and like other professional interviews (job interviews; therapeutic interviews) there was an expectation that I asked the questions and the participants responded. I arranged the first interviews and selected the topics and questions to be asked. The second round of interviews were more open-ended, and we followed the conversational flow. However, the way I responded to the answers the participants gave would have influenced the consequent discussion. As a research interviewer I also acted as an audience for the participants. The participants may have wanted to influence me in some way. Even if I had said nothing, I would still have acted as a responsive audience and as such influenced what was talked about.

4.3   Selection and Recruitment of Research Participants

Participants were selected using opportunistic sampling (Sells et al., 1994; O'Connor, et al., 1997). In April 2001 the members of the therapy team were sent a copy of my initial research proposal and invited to participate in the research study. Following their agreement I then requested each member of the team to think of a family they could invite to participate in the study. Families could be given a choice as to who would volunteer to be interviewed. After the therapist had spoken to the

family about the project and the family had agreed to think about it, I was then given a name and contact telephone number. I then rang the family, introduced myself and explained the project briefly. If they were in agreement I then sent them out an information form and we arranged a time to meet.[9]

In regard to the selection of participating therapists, the advantage of this form of sampling was that I could select people I had already established a working relationship with. This allowed for the development of cooperation, trust and mutual understanding. The therapists were sympathetic to this form of research and were generous in their time throughout the course of the project. The advantage of inviting the therapists to select their own family was that the therapists had already established a relationship with potential client participants. If the therapists trusted the researcher then the clients would be more open to considering the research request. All the clients who participated chose to be interviewed at the agency. The disadvantage of allowing the therapists to select their own clients was that they were more likely to choose clients who would report positively on their experiences. This would affect the findings by increasing reports on the helpfulness of the therapy process but decrease the chance of receiving reports on the unhelpfulness of the project. Clients would therefore be unlikely to say things that could be taken as a criticism of their therapist.

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[9] Although all three members of the team were interviewed, the client selected by Dr Ros Powry pulled out at the last moment. Hence only two sets of paired client-therapist interviews took place instead of the three that were originally planned.

4.4   *Designing the Interview Guide*

I decided to construct a semi-structured interview guide for my first round of interviews.[10]   Following my literature review I identified five lines of inquiry:

1. Experience of the client/therapist before meeting each other; what were their expectations or preconceptions?

2. Their experience of the agency;

3. Their experience of the first session;

4. Their experience of self;

5. Their experience of the therapeutic relationship;

6. Their experience of outcomes and therapeutic practices.

These themes had been consistently referred to and identified as important to shaping the experience of therapy by earlier researchers in the process research field (Elliot & James, 1989; McLeod, 1990; Rennie, 1992). My interview guide was structured along these six lines of inquiry and included a number of suggested questions under each topic. At the same time there was an openness to vary this sequence and to "ad lib" questions in response to the participant's story (Kvale, 1996, page 124). I remained open to exploring the full range of experience identified by clients and therapists as significant. It was assumed that all these factors would contribute to the clients overall experience of outcomes. However, I did have a special interest in understanding what both clients and therapists found uniquely helpful about their experience of meeting in the context of a reflecting team process and participating in this kind of research project.

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[10] See Appendix One for a copy of the Interview Guide.

Kvale (1996, pages 83-97) convinced me that I needed to thematic before doing any interviews. That is, to clarify the concepts and do a theoretical analysis of the themes (lines of inquiry) to be explored and formalise the research question. This, he claimed, would also ease the transition from data collection to data analysis in that the data analysis could be structured along similar thematic lines. I therefore did an extensive review of the literature on previous research into the experience of the therapy process, before designing my interview guide. I agreed with Edward Bruner (1986) that the researcher goes to the field with a dominant story already in mind:

> . . . and that story is foregrounded in the final professional product, the published article, chapter, or monograph. If we stray too far from the dominant story in the literature, if we overlook a key reference or fail to mention the work of am important scholar, we are politely corrected by such institutional monitors as thesis committees, foundation review panels, or journal editors. At the beginning and end the production of ethnography is framed by the dominant story (page 146).

This fitted with my own conclusion, drawn from my inquiry into methodology, that the researcher cannot transcend their own location in history by applying a procedural methodology. From the perspective of a reflexive methodology therefore, it was important to acknowledge and make explicit the pre-understandings (dominant story) that were formed from my reading of the research literature and to show how this reading determined the structure of my interview guide, the co-construction of the interview conversation itself and my discussion of the implications of the research findings.

5. Data Analysis

5.1 Representation and Analysis of the Transcripts

I came to the view that the transcript (research text) is a written translation of the audio tape and hence always an interpretation. The ideal of getting an accurate representation of the actual conversation by having a finely detailed transcript, as in some approaches to discourse analysis, did not seem appropriate or relevant to me for this type of study. A 'good enough' transcript would do, one that was easy to read and user friendly without being complicated by an attempt to symbolise the actual sound and context of the conversation. It could be authenticated by giving a copy of the final version to the interviewee and asking for them to suggest changes if necessary.

I have argued above, following Mishler (1986) and Kvale (1996) that qualitative research interviews are "joint productions" of both interviewer and interviewee. However I was responsible for the interview transcript itself. I agreed with Gadamer (1960/2001) that the "true" meaning of the text does not reside in the intentions of the author (in this case, the interviewee) but again is a joint production of the reader and the text. Finally, all transcripts were read by the interviewees and they were informed that the transcript was open to revision if they wanted to change any aspect of the text.

The reflexive-dialogical approach to data analysis I adopted for this study aimed to both empower my co-researchers and make visible the process of co-construction of the data/findings by clarifying and commenting on what was informing my questions

and allowing the participants' to read and comment on what was interesting to them in the transcripts.

One of the commonalities of qualitative research is the need to condense and re-present the original research text. The difficult I had with most qualitative analysis was that it was the principal researcher only who did the analysis. This positioned the principal researcher at the "center" of the meaning construction process. My dilemma was to find a way of condensing the text without resorting to imposing too many layers of interpretation. The answer was simple. For the research interviews I conducted with the clients Jane, Debra and her eldest son, Danny, I used the basic editorial tools of selection, quotation, summary and commentary in order to re-present their interviews in a condensed form. I acknowledge these simple procedures are still selective. In my editing I was emphasising some features of the original and down playing other features (Gadamer, 1960/2001, page 386). However, I felt the summaries contained enough original transcript material to give the reader a genuine experience of the voice of the client participants. I decided to condense the conversational text by making editorial decisions as to what to quote in full and what to delete. The extracts that were deleted were then summarized in order to provide the links or bridges between the text fragments which are fully quoted. The summary is a practice that is commonly used in therapy and can be easily checked against the full text for accuracy, in the same way that client's themselves authenticate the summary during a therapy session. I differentiate the commentary from the summary. I do this because the commentary can be seen as an interpretation by adding an extra layer of meaning by using words or meanings the client may not have chosen. In this sense it can be argued that I am providing a kind of retrospective commentary on the

dialogue. I believe this clearly distinguishes my voice without my voice becoming the dominant voice of authoritative methodology. It is simply a reflection on the text and should be read in the same spirit as a client listens to the reflections of a reflecting team.

For the research interviews I conducted with the therapists Carole and Andrew, I decided to condense the research text by grouping the major themes of the interview that I had identified, into sub-headings and sending them back to both Carole and Andrew in the form of a "research" letter. Again, in the research letters I tried to stay as close as possible to the actual words used but some editorial decisions had to be taken regrading what to leave in or out and what to quote in full. I felt these interpretations (in letter form) were a continuation of the dialogue and hence open to revision following feedback from the therapists concerned. In this way, I felt that the meanings I had highlighted were made accountable to my co-researchers by their authentication of the letters.

5.2   *From First Order to Second Order Interviews*

Second order cybernetics had been influential in family therapy and paved the way for the reflecting team innovation. The same idea had also been introduced into research (Steier, 1991; Gergen & Gergen, 1991). I decided that I would involve the therapists in a second interview inviting them to comment on their experience of reading the transcripts of their own interview and the interview with the client. This solved my problem of not wanting to do an "expert analysis" of the data, whether it was some form of grounded analysis or discourse analysis. The participants

themselves would be invited to reflect on the transcripts within the context of a meta-dialogue or "re-telling":

> In Narrative Therapy, the therapist invariably explores options that structure their work in ways that are decentring of them and that contribute to the tellings and the re-tellings of the stories of person's lives. These are not just any tellings and re-tellings, but ones that contribute to these stories being more richly described. These re-tellings contribute to powerful acknowledgements, and are authenticating of persons' preferred identity claims (White, 1997, page 205).

Hopefully, we would all learn and benefit in some way from participating in this extended research conversation. Participating in decentred research conversations can often be a transformative process and I thought the therapists who participated in the second order interviews would have an opportunity to reflect on and review some of their therapeutic practices. This could lead to a rich affirmation of the therapeutic tradition they located themselves in as well as their own possible unique contributions to this tradition that may often go unrecognised and un-storied without the benefit of reflection. I therefore framed two simple follow up questions for the second interview:

1. What stood out as significant for you, when you read the transcript of your own interview about your experience of the reflecting team process?

2.   What did you learn from reading the interview about your client's experience of the reflecting team process?

I then invited the therapists to be interviewed a second time and made another transcript. The understandings articulated by both clients and therapists would then form the basis of the research findings.

I justified not inviting the persons who participated in their role as clients to a second interview on the grounds that:

1.   I didn't want the research to intervene too radically into the process of therapy;

2.   That the persons participating as therapists had a professional interest in reflecting on their work as a reflecting team, whereas the persons who participated as clients had a personal interest in their own lives but not necessarily the finer details of therapy and research practice; and

3.   Persons who participate in research as "subjects" often have different purposes to the researchers who initiate the research (Bloor, 1997). In this case, clients wished to share their experience if that could be helpful to others.

This could be seen as unbalanced, but I felt this honoured the different life worlds and interests of the participants.

6. Alternative Justification Principles to Validity

Findings in the natural sciences are validated or verified by their *replication* by a second independent investigator. Unless findings in the natural sciences can be replicated, they have no validity. In the human or social sciences, by contrast, validation cannot occur through subsequent replication, since identical social circumstances cannot be re-created outside the laboratory (Bloor, 1997, page 38). Therefore, ever since the 19th century the human sciences have attempted to find alternative verification principles similar to the natural sciences in order to justify their findings. They have developed two main techniques which may be considered as alternative methods of validation. The first of these is 'triangulation' whereby findings may be judged valid when different and contrasting methods of data collection yield identical findings on the same research subjects. The second technique, or rather array of related techniques, judges findings to be valid by demonstrating a correspondence between the analyst's findings and the understanding of members of the collectivity being analysed (Bloor, 1997, page 38). In contrast to the above, a decentred research practice offers a third way. It does not seek alternative methods of *validating* findings. Validity is not seen as being relevant to research which is based in the narrative mode of thought. However, it does seek alternative principles or criteria to *justify* findings.

According to McLeod (1997), practitioner researchers into therapy will always have trouble validating their findings. McLeod believes there are special criteria that are applicable to all practitioner research regardless of the specific methodology they have developed or chosen for their study:

It has already been suggested that to be able to develop knowledge that enriches practice, it is necessary to be as explicit as possible about the organisational and personal context within which the research was carried out. This principle leads to the following criteria for practitioner research:

1. A good practitioner research study will provide sufficient descriptive detail of clients, counsellors, the counselling approach, setting, social and political context, etc., for readers to be able to make informed judgements regarding the similarity and applicability of the study to their own practice;

2. A good practitioner research study will provide sufficient information on the personal engagement of the researcher(s) in the study, and their heuristic process, for the reader to be able to make a judgement concerning authenticity, 'ownership' and personal integrity (McLeod, 1999. page 18).

I believe this practitioner study meets the above general criteria. However, I felt I needed to supplement these general criteria by more specific criteria relevant to a decentred approach to research practice. Although these are related to the second technique as described by Bloor above, there are some fundamental differences. This is because decentred research differs from most research in that the findings presented *are the understandings of the research subjects themselves*. The researcher may discuss the implications of research findings in relation to the

literature, but the findings are not the result of the researcher's analysis. The findings are not the end result of the application of a procedural method but are the end result of understandings arrived at through reflexive dialogue. Although in this particular piece of research, the transcripts of the reflexive dialogue were subjected to a reduction into meaning units in order to be condensed into a letter, I would do not see this as the application a procedural method. Rather, it is a technique for structuring the findings which does not claim to eliminate the subjective bias of the person doing the editing.

I therefore developed three alternative principles to traditional notions of validity as a justification for the various levels of interpretation that take place in decentred research. The first level being between participant and research interviewer; the second being the actual transcription and summary process and finally, the participant's interpretation of the transcripts. The three principles are (1) using writing as a method of reflexive inquiry and (2) developing a two-way account of research and (3) authentication.

6.1 Using Writing as a Method of Reflexive Inquiry

Most journal articles give a formalised picture of the research process in much the same way that presentations of therapy stories are "glossed" and "do not adequately represent the disorderly process of therapy" (White, 1993, page 22). This is often encouraged by editorial requirements that "promote a distorted technical picture of scientific research as a logical, linear process – which is far from the continually changing actual research process with its surprises, design changes, and

reformulations of concepts and hypotheses" (Kvale, 1996, page 83). I therefore wanted to write about my research in an experience-near style to which narrative lends itself, rather than the experience-distant style of most paradigmatic research reports (Geertz, 1973). I was committed to personalising and telling the story of my research journey as part of my methodological commitment to reflexive research and writing as a form of discovery. Reflexive research is, by definition, inclusive of the self of the researcher(s) in the final write-up of the research report (Steier, 1991). The style in which I chose to write this dissertation was therefore both a political and methodological act, aimed at making my subjectivity visible, unlike traditional academic writing which aims to render the subjectivity of the researcher invisible. This commitment to reflexive writing seemed to fit with my approach in that it supported my commitment to rendering my prejudices visible while at the same time embodying a dialogic approach to meaning making.

6.2   A Two-Way Account of Research

Traditional accounts of research are predominantly one-way accounts, in which the researcher, through the use of various "methods" extracts knowledge from the research subjects. The research subject is constructed as the 'other' that these methods act upon. White (1997, page 130-132) describes a "two-way" account of therapy, whereby the therapist acknowledges the contribution the person who has been consulting them has made to the development of their skills and knowledge. In the same way, I thought a two-way account of research would discuss the effect on the researcher(s) of entering into a research relationship. Research subjects in two-way accounts of research are constructed as "participants" or "co-researchers" who act to influence or change the understandings of the principal researcher(s). A two-

way account of research challenges the traditional power relations inherent in most research discourse. A two-way account of research both foregrounds the interpretations of co-researchers and contributes in significant ways to the professional development of the principal researcher. It helps to clarify, refine and re-story the principal researchers own way of thinking about and practicing therapy and research. This will be evident throughout the dissertation as I describe my research journey, but I will also return to this question at the end of the final chapter when I describe how participating in this research contributed to the enrichment of my own professional identity as a practitioner researcher.

6.3   *Authentication*

The understandings of the co-researchers are authenticated by the co-researchers themselves. They can edit the research findings if they do not feel they are an accurate representation of their meanings. In this study the participating clients and therapists were each given copies of the transcripts in order to authenticate them. Both the first and second research letters were also authenticated by the therapists.

Some of the principles that are used to justify research findings in decentred research, such as authentication, do share a family resemblance to the concept of member validation often used in qualitative research, but differ significantly. Member validation is used to validate the *analyst's* findings by "demonstrating a correspondence" (Bloor, 1997, page 41) with the research subjects own descriptions, whereas the practice of authentication in decentred research is simply the research subjects themselves bearing witness to their own understandings, presented as the findings.

7. Discussion of the Implications of the Research Findings

It was not until the dissertation was almost complete that I realised that my discussion of the research findings mirrored the structure of reflecting practice. I came to the conclusion that in a decentred' research practice I could not justify to generalise about the implications of the findings for other practitioners, but only focus on the implications of the findings for my own practice. It was this decision that led me to understand how the pattern was now complete:

1. First order interviews and transcripts (reflections on experience);

2. Second order interviews and transcripts (reflections on reflections); and

3. My reflections on the above.

In this way the subjectivity of the principal researcher was formally incorporated into the text without speaking as the final voice of authority on the findings. Rather, the reader is hopefully left with their own unique reflections.

8. Conclusion

I have argued that in a decentred research practice, subjectivity and relativity do not in any way reduce the possible pragmatic usefulness of this form of research. Methodology is usually premised on the need to eliminate subjective judgement. In contrast to this, as my understanding of decentred research practice developed, I saw

that ethics, rather than validity, was the key to justifying my research findings (Crocket, 2004). Also, because the principal researcher is not central to analysing the data, I therefore did not seek to counteract my subjective prejudices by using a method such as grounded theory. This is because the need for an exact procedural method is not necessary in decentred research practice. I abandoned the notion of "objective knowledge" and "realism", preferring instead the pragmatics of local knowledge, which I felt to be more relevant to practitioners. However, I do not think this leads to "anything goes" relativity. Rather, the findings are justified according to alternative criteria to validity which are grounded in an ethical commitment to reflexivity, respect and transparency.

CHAPTER FOUR: RESEARCH FINDINGS

1.   Jane[11]

Jane is a white Australian woman in her thirties, who is the single parent of Paul, a five year-old boy. Jane had only experienced two sessions with the reflecting team at the time the interview took place.

1.1   *Interview Setting/Process*

The interview lasted for one hour and took place in one of the counselling rooms at the agency. The interview was audio-taped and a semi-structured interview schedule was used. This allowed me to be both spontaneous in letting the conversation flow where it willed, while at the same time also allowed some common structure, which would be of help during the analysis stage of the research. I enjoyed the interview with Jane who spoke openly and fluently about her experience. Her rich descriptions made my job easier.

1.2   *The Interview Summary*

Client Expectations

I began the interview by asking Jane to tell me why she contacted the agency and what expectations or previous experience she had of therapy. Jane explained that Paul, her five year-old son, "was showing signs of not being able to manage his anger, and was becoming quite physical and verbal". This anger was "mostly

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[11] All client names are fictionalised to protect the identity of participants.

directed" at Jane. Jane believed that because she "suffered from depression", she "found it very difficult to deal with". Jane thought the way she was parenting Paul was not effective and she wondered if was she was doing the right things. Jane felt she "wasn't coping", and so decided she "needed to speak to someone". Fortunately, she "knew that there was someone" she could go to, and that she "didn't have to do it" on her own. A friend of her mother, who used to work as a children's counsellor, pointed her in the direction of the agency.

Jane's expectation was the hope that she would receive some tools or techniques to use: "I mean we all want a magic wand, I just wanted Paul to stop what he was doing". Jane knew she wasn't going to get a magic wand but she hoped she "would be given some sought of guidance and direction". Jane's apparent confidence and belief in the process of counselling led me to ask her if she had any prior experience of counselling on a personal basis. Jane related a story about how she saw a psychiatrist for treatment for depression. There was a "lot of talk" which she found "quite beneficial" and she "resolved a lot of issues through this process". She also told me she had done a lot of reading "dealing with emotional health" and she had recently completed a personal development course.

I then introduced the next question, regarding Jane's initial experience of the agency and the agency environment. She related how she rang the agency and had a helpful conversation with the worker on intake who made an appointment for her with the family therapy team. She thought the intake worker had listened and asked relevant questions. She felt he understood her story and most importantly that her "concerns were real". She also felt very encouraged that she was given an appointment straight

away.

First Session

We then moved on to discuss her experience of the first session. It was all very positive and began the process of revising her view of herself as a parent. She also liked how it was very inclusive, especially that the team included her son, Paul as a participant who "heard everything that was going on". The opening comment from the team congratulated Paul for how well he handled himself "and he just beamed with that, he heard someone saying something wonderful about him, so you know straight away there was this, he had feeling of well you know, these people are okay". In particular, Jane liked the experience of swapping places with the team, because it gave her the unique experience of being an audience to her own story:

> ... Paul and I got to listen to what the team had to say, it was sort of like being able to move away from it personally ... it was like stepping outside of myself ... from a different perspective or angle ... I mean you weren't just listening but you actually heard things, that ... you may not have picked up if it was just a one-to-one and them telling you what they thought, because they were using my name, it wasn't a personal thing, and that Paul was there, he could hear their feedback as well (73-81).

Jane had helped prepare Paul for coming to the session by describing the therapists as "doctors", who were there to help them stop being so angry with each other so they could feel happy again. I asked Jane if they were feeling relaxed and comfortable at the beginning of the first session. Jane described herself as "feeling

slightly anxious" about coming to the session. She was worried the team might think that it wasn't really a big enough problem, that there was really "nothing wrong" and she was "overreacting". She also worried she wasn't "going to be able" to find the "right words" to "convey" what she was "really feeling and going through". However, she was able to reassure herself that the team would be "understanding" and once they settled down in the room she "felt very relaxed" and she "didn't feel uncomfortable at all".

I asked Jane if there was anything else about the first session that was helpful. She commented that she felt the extra input was helpful because she had seen three therapists, each with a slightly different perspective. They either came up with something the others hadn't, or confirmed what another person had thought or expanded on it, so Jane felt there was a "lot more feedback". I asked her what she felt she took away by the end of the first session in comparison to the expectations she brought with her and she replied that she "felt a certain amount of relief" because she "felt that the team had a very good understanding of the situation" and "that there was something that needed to be dealt with", that in fact it wasn't just her "overreaction". Although Jane felt that she didn't come away with any tools or techniques, or a better understanding of right or wrong ways of doing things, she did come away "with the expectation" of "that would come and that something was happening". She also felt that Paul "had experienced something that was positive for him as well." In conclusion, she felt she "came away with a feeling of hope", whereas she felt "sought of hopeless before".

Experience of Self

I then introduced the next topic of the interview schedule which was intended to explore Jane's experience of her self as a mother and her relationship with Paul before therapy and how this might have changed during the course of therapy. I started by asking Jane how she was feeling and thinking about herself and her relationship with Paul *before* coming to therapy with the intention of exploring if this had changed at all. She answered saying that she felt that she "wasn't doing a good job" and she "wasn't coping" and didn't like "being a mother". It felt like it was "all too hard" and that she couldn't do it any more. She had just started taking "medication" because she was "feeling quite depressed", whereas previously she had "been able to deal with it without it ever getting to bad." Now she felt she was "sinking", and "if I didn't get on top of my depression that I wouldn't be able to deal with Paul even though I knew I needed to." After the session, Jane's problem saturated story of how depression had been affecting her relationship with Paul was no longer as dominant:

> after the session I guess I felt a bit uplifted ... I felt quite relieved ... having made a move to get help I felt as though the responsibility wasn't all mine ... that I was able to offload a bit ... I've got someone there that can help ... I was feeling much more positive, I did sort of come out of that feeling of hopelessness, I didn't feel 100 percent but I know I was feeling much better ... where I might have, or had been, losing it when Paul was having his tantrums or whatever you like to call them, I was able to remain calm and ... confirmed after the first session ... if I remain calm and don't go off the deep end that Paul responds to that, he may still be having his crack-up but it doesn't last as

long and is not as severe, and then we talk about it, once he's calmed down ... after the first session, I felt like I could deal with it ... there was light at the end of the tunnel ... it wasn't as hopeless as I had perceived it before ...my own perception of life was much brighter and therefore I was able to deal with things in a much more rational and calm way (201-219).

Jane then went on to describe how she felt she had been lacking quality time with her son because she seemed to be so busy all the time, and she "didn't have the energy". She just didn't want to spend time with Paul because they wouldn't enjoy it, because he would "always find something wrong" with what they were doing and he'd "get upset" about "minute things". Once Jane's feelings changed, when she started to feel "much brighter and more positive" about herself then she could "look at it from a different angle" and "then really do something about it"; so Jane thought that "had quite an effect":

> I guess the sessions have enabled me to ... move away and look at it from a different angle and less personally, and see things that I haven't either seen before or seen them in a different light (241-243).

One of the major insights for Jane from the sessions was how they helped her to clarify that it was no use trying to work on her parenting relationship with Paul until she was feeling in better emotional health herself:

> ... if I'm not in my best emotional health, then it's not going to work, so the priority was for me to get well, before I could seriously tackle the other

problems ... that was something I sort of knew but I didn't acknowledge it, but it became so much clearer, having heard it coming from professionals ... (279-284).

The Therapeutic Relationship

I then moved onto the next topic of the interview which was exploring Jane's experience of the therapeutic relationship. In this section I explored a number of factors that are often confirmed by the research literature as being significant to the establishment of a therapeutic alliance: the client's perception of the personal qualities of the therapist (Rennie, 1992); the way in which talk is managed by the therapist and the de-centering of therapist authority (Kogan & Gale, 1997); the personal contact established between client and therapist and therapist use of self (Elliot & James, 1989; Kogan & Gale, 1997).

Jane found talking with Carole "very easy" and "comfortable". She had no "feelings of intimidation or judgments "so she felt quite "free to talk about anything". I asked her to comment on how important it is to therapy to have that kind of relationship to Carole and the team:

I think it's quite important because ... this whole sort thing is based on ... total openness and honesty, and if you feel that you have to hold back, if you're are not feeling comfortable with someone, you're probably likely to hold back a bit on some things that really may be quite important, so I think ... if you don't feel comfortable with them, or if there is something you dislike about them, you're not quite as willing to listen or to hear what they might

have to say, if there is something negative to be said, you may not want to hear it coming from someone that you are not so keen on; whereas if it is someone you have a good rapport with, you're willing to at least listen to it and then maybe think about it, and then you can either discard or accept, but I do think it plays an important part (345-355).

I then explored how Jane experienced how the topics that were discussed in therapy were chosen. Did she feel that she was in charge of the therapy or did she feel the therapist was in charge? Did she feel that she was being treated as the expert, and did she feel the therapist was following her lead or did she feel she was following them?

I think, that's actually a hard one (laughter). I think maybe equally so on both sides, I guess, I don't know that I felt like the expert, but I felt that what I had to say was valuable, that I was the one in the situation so I was the one to give the information (pause) I guess I just felt that it was a participation thing, that there was no one more expert than the other (365-369).

Jane did feel she was talking about what she wanted to talk about, and what she had to say was very much respected: "I did feel that there was respect for me as a human being".

I explored Jane's sense of *personal contact* with the therapists. She felt she could laugh and talk about things that were not related to why she was there, "which was good". She couldn't remember Carole disclosing or sharing anything about her own personal life, or her work with some other people, but a member of the team did and

she found this was a helpful thing to do because "you saw that they were just ordinary human beings too, people that have problems, that you know, that are parents too, and didn't have perfect angels either".

Therapeutic Outcomes

The research literature sometimes talks about pivotal moments or turning points within a therapy session. I decided to ask Jane if she had experienced a moment in either of the sessions that may have been significant. I illustrated this by suggesting it may have been a particular comment by a team member that stuck in her mind. She remembered a moment in the first session when she heard the team suggest "something that had never entered" her mind, and so it "sort of stayed with me. It was that one of the things Paul was probably suffering from was separation anxiety, and it had never occurred to me at all." Jane explained that she had originally thought the problem was "anger management" and she thought Paul was "very much into trying to control me" by for example, always wanting to know where she was and not allowing her "to do something by myself without him". So while Jane had been interpreting this behaviour as "control" it had "never occurred" to her that part of it may have been separation anxiety. This was "a big thing" for Jane that she "hadn't thought of it." This therefore seemed to be another example of how the team reflections succeeded in giving Jane a different perspective – from viewing her son as trying to "control" her to seeing her son as emotionally vulnerable and insecure.

The final topic on the interview schedule was to explore the so-called extra-therapeutic factors such as family support and how helpful this was compared to the

help she received from therapy. She found her family to be very important but she still felt that she "needed professional support" as well:

> Well I guess, I don't think I would have survived as well as I have if I hadn't had my family and I think having a support network, I think, is extremely important, especially a continuing one or two. Having professional help, is I think as important for me, but just on the short term, its not there the whole way through (420-423).

I concluded the interview by inquiring how Jane found the experience of being interviewed about her experience of therapy. She thought that it was like having an "added session" of therapy. It helped her clarify things and it refreshed "thoughts and ideas" that sometimes get forgotten in the busyness of everyday life where we tend to "put things away" and "forget to re-look at them". So the interview gave Jane another chance to review some of these thoughts and ideas. She concluded by saying: "so it's another form of reflection and re-looking, you know, opening the box and having another look! So yes, it's good."

2.   Carole Meech

Carole started working at the agency in 1984 after completing her training in general and mental health nursing. The major influences on her as a therapist have been narrative and solution-focused therapy and the work of Milton Erickson, introduced to her by Andrew Wood. As well as family therapy, Carole also enjoys child play therapy assessments and treatments.

2.1 Interview Setting/Process

I interviewed Carole in her office with a tape recorder following my interview with Jane. The interview was approximately one hour. Although the interview may have got off to a nervous start I felt by the end of the interview Carole enjoyed the opportunity to reflect on her work. At the end of the first interview I asked Carole what it was like being interviewed about her work and she replied: "A bit weird. I don't mind talking about the process, I'm not sure, I'm not very good about talking about my feelings and stuff, I don't like doing that very much. Talking about the process was really good though because I thought of some things about the reflecting team that I hadn't thought of before (532-535)."

2.2 The First Research Letter

As an alternative to translating the interview into narrative form as I did with the clients I decided to use the form of a letter. Letters are often used in narrative therapy in order to summarise the themes covered in therapeutic sessions, and I thought they could play an equally helpful role in research. I also thought they captured the spirit of ongoing partners in dialogue, given that both Carole and Andrew were involved as researchers who were also interpreting the meaning of the first round of interview conducted with their clients and each other. With both Carole and Andrew in the first research letter themes where identified on the basis of an analysis of the transcript into meaning units. In the second research letter, the transcript was analysed into meaning units but then grouped under the thematic headings identified previously in the literature review. This was done in order to

facilitate comparison of the findings and enable an easy transition to the discussion of the significance and implications of the research findings in the last chapter.

09.02.03

Dear Carole

Thank you for participating in the research project. Enclosed within is a transcript of your second interview, which I hope you find of some interest. As with therapy, so with research, we often would have done things differently with the benefit of hindsight. I have belatedly decided to write you a letter summarising some of the main themes we spoke about during your *first* interview. I wish I would have done this *before* I interviewed you the *second* time. The process of writing this letter has helped me to condense the material as well as stay within the collaborative spirit of my research methodology. This letter together with your second interview take the place of the traditional qualitative analysis stage of a research report carried out by the researcher. When you have finished reading this letter I would appreciate your feedback on would it have made it easier to have received a letter like this before the second interview? Also, if you think I have misunderstood you in any way please let me know.

How the Team makes a Difference to your Therapeutic Work
One of the themes that stood out for me was how the presence of the team makes such a difference to your experience of therapy and yourself as a therapist. When you

reflected back on your work with Jane you focussed a lot on the reflecting team *process*. You contrasted working on your own to working with the team, arriving at the seeming paradox that you feel both (1) more relaxed and less pressured when working with the team and yet (2) more rigorous.

For example, when you are seeing a family with the team you don't worry as much as when you are on your own. "If I'm working on my own I have to think ahead a bit more, about well what am I going to do next with this family or what am I going to send this family away with. I do a lot of thinking about that while I'm trying to concentrate on the session, but when the team's there I don't have to do that, I can just concentrate on what I'm doing in the room (45-48)". This seems to indicate that when you relax more you can be more fully with your clients without letting planning thoughts interfere with that. That suggests to me how much trust and confidence you have in the other team members, because I know from my experience that I can often let myself worry that the team might be critical of for example, the questions I am asking. This can create an anxiety which then gets in the way of being able to relax and be spontaneous. You have a confidence that the team is not judgemental of you because "I know if I go off the wrong track or if I get stuck or if I'm struggling I can either stop and go and talk to them or I can, or I know that they will come and knock on the door, and set me on the straight and narrow (49-51)."

The presence of the team lends more rigour to your work because you are conscious of being observed. This also has "spin-offs" for your individual work. When working without a team "there is a danger of getting a bit relaxed (67)" in the sense of not being as rigorous about following a process. But when "there are people

watching" you feel more "accountable for my practice (68-69)". We explored some further meanings of therapeutic rigour and you talked about being more "mindful of the process". By "process" I understood you to mean both the organisation of the reflecting team ritual and the way in which you went about constructing a therapeutic conversation with your clients. It is important to you that you don't "get into telling, that I continue to ask questions, and open up those sort of things for the clients, rather than getting into the explaining (87-88)". There is always a danger that without a team, you might get "lazy" and fall back into old habits of explaining "rather than asking the questions so that the clients have to get into their own explaining (90-91)."

What was Helpful or not Helpful to the Client?

When we discussed your perceptions of what may have been helpful to the client in that first session you based your response on what the client actually said in the session rather than on your own feelings. I thought that this fitted very well with my learnings from the research literature in which client perceptions of what was helpful can often diverge from therapists perceptions of what was helpful. You were therefore pretty spot on when you commented that you got the impression that Jane "felt that she wasn't being dismissed, or that her concerns were silly or any of that sort of stuff, but I think more than anything, was the sense that I got from her that she felt that she had been heard and that what she was saying was meaningful and made sense and that where we were moving from was from that point, so we agreed with that what she experiencing was important and was meaningful and wasn't just a figment of her imagination and then we could move on from that point, and that was the feeling I got, from her (98-103)."

It came across to me from your comments about what might not have been so helpful that you are also seeking to find ways of becoming a better therapist. I remember, especially from our second interview, how disappointed you were that Jane was so positive about her experience with the team! It seems that you look for constant feedback from the client to let you know that you are staying on "track". Again this makes sense to me as well, from my reading of the research literature clients can have an acute sense of when the therapist wanders "off track".

In terms of tuning into the client I found it interesting that you preferred the term "pacing" rather than "empathy". For you pacing means "making sure I'm not going too fast, but there are things that I need to find out, they need to tell me about, so I think it's about pacing yourself with that person and I think its about making sure you are open minded enough so that, so that you hear what they are saying, you're not just listening but actually hear what they are saying, so if that's empathy ... (195-198)".

The Therapeutic Relationship and Reflecting Teams

Another question we explored in the interview was how we think about the therapeutic relationship when working together with a team. For example you saw yourself as a therapeutic team rather than an individual therapist working with a team. You don't experience yourself as being separate from the team. And you also thought that for the client they also experienced the primary relationship with the team rather than with the therapist who was doing the interview. You saw this happening from the moment the team does their first reflection, which you felt

"changes the nature of the therapy (227)". Your tentative explanation of this was in your experience it seems that when the team reflects, the clients pick up more on what the team members behind the screen have to say because "they are that bit removed, I think their reflections for some reason are a bit more powerful and I think clients really take note of what they say and if they take note of what they say like in the way that I think that they do, and I believe that they do from what they say, you know when we swap back, then we will do any subsequent sessions I think that team idea is much more powerful (238-242)."So you become "less of an individual worker after the first session" (251) and you think that the reflections of the outsider team members are "more meaningful because they are not in the room" (254).

You also had some comments to make on the ethics of the therapeutic relationship in the context of reflecting team work. You used the word "equity" to describe the process, "we watch them and they watch us" (264) making us more accountable to them. The team members in this process can't "muck about" and have to "stay on track".

The Team Culture and Relationships

The topic of the team culture and relationships is, I think, often neglected in the literature, so it was great to hear your thoughts about this. In many ways I felt that your team is quite unique in the history of reflecting teams because you have worked together on a consistent and regular basis for I think eleven years? The benefits of this came out in so many ways throughout the interview. The trust that has developed between teams members leading to a confidence and freedom of expression as

therapists was notable. Also the ability to tolerate differences of opinion "because we've been working together for a long time, so I feel, I feel quite confident ... about what they are going to say, even if we have a difference of opinion is going to be OK, its not going to be disrespectful or interrupt the therapeutic process or undermine my role in it ... I think that just comes with working together for a long time and having confidence in each other's abilities (271-276)."

You also find the team really supportive of your professional identity. Like it is easy to be our own worst critic but the team can also provide positive feedback that maybe we sometimes don't get from the client. Although sometimes you would like the team to spend a little more time in critical reflection on you're work because you're open to your work being critiqued.

But above all else it seemed to me that you really valued your relationship with your team members. You have been on teams that haven't worked and where one team member has tried to impose their way of working. Not surprisingly, you think "the relationship between team members is crucial" (495). You think the quality of reflections is dependent on these relationships because in that reflection you think "it's important that nobody seems to be in charge" (496). Relationships need respectfulness and equity. You worry that "if you were working in a team were the style was different or somebody had a really strong opinion and didn't agree with what was happening" you think "that can undermine the therapeutic relationship between the primary therapist and the client" (500-501). You conclude "maybe part of the role of the reflecting team is about adding credibility to the primary therapist which strengthens the primary therapist and the client relationship. Because if you

had a team that undermined the primary therapist or said 'oh I think you're going down the wrong track or it was a lots of bollocks or whatever' then what would that do to that relationship between the client and the primary therapist?"(504-507).

So there also needs to be something of a fit between team members styles, which doesn't mean you can't have differences of opinion but share a commitment to a particular style of therapeutic conversation which favours asking questions over explaining. Also some common ground around compatibility of therapeutic traditions you would also see as necessary to a successful reflecting team.

Therapeutic Conversation Topics and Comfort Zones

I was also interested in your thoughts on who determines the topics that are discussed within the session. You thought that had to be a mutual process and that again you would always be looking for feedback from the client. You gave a good example I thought about how sometimes as a therapist we need to step into possibly uncomfortable areas for the client in order to place the focus on the child. In Jane's case you gave the example of exploring the effect of Jane's mental health on her ability to parent Fraser and judging from my interview with Jane this was certainly a very meaningful exploration for her.

The Clients Contribution to Therapeutic Outcomes

Your interview also helped me to see again how it makes our work easier when our client brings a certain trust to the collaborative process of therapy. The therapeutic alliance seems to develop really quickly. In your experience you have found that

clients, like Jane, who take the risk of exposing themselves to a reflecting process, are already displaying a certain degree of courage in facing up to problems. You find that they come along "with a really open mind" (383) about therapy, as compared to some clients who have a fixed view of what they want and what may not be possible. So that to some degree there is already a self-selection process occurring. Like you say, "if families have got that sort of courage and open mindedness then maybe that makes them more open minded and willing to consider some of the comments from the team" (407-410) and I wonder if we could not use this more in our therapeutic conversations with families who consult us?

The Humble Therapist

Finally, the image that stays in my mind more than anything is the picture you painted of the "humble" therapist which I could really relate to. You say its good even when we have not done a good job because it "keeps you humble", that mistakes are an inevitable part of our life as therapists and it doesn't matter how long we have been working:

> I believe that a good therapist is humble, I don't think an arrogant therapist can be a good therapist, because you have to be able to learn from your clients and you're humbled by their response to what you've done, in a way they're telling you, they're teaching you about your therapy ... and they judge us as to what we do (453-457).

So in a way mistakes stop us from getting arrogant and keep us in touch with that "not knowing" stance that Harlene Anderson talks about. We can never be perfect therapists, in the same way that Winnicott talked about there is no such thing as the perfect mother. Some psychotherapists (from the object relations school) also talk about how important it is for the therapist to be able to repair a relationship with a client because so often in a client's life they have never experienced that!

Well, once again thank you for your thought provoking interview, kind regards,

Andrew.

2.3   *The Second Research Letter*

03/02/04

Dear Carole

I have decided to write you a letter, documenting what I am describing in my thesis as the "research findings" from your second interview. In this interview you were invited to comment and reflect on what stood out for you after reading the transcripts from both your own and your client's first interview. This placed you in the position of an audience to the reflections and stories your client told about their experience of the reflecting team. In this way our research practice parallels the process of a therapeutic reflecting team.

I "analysed" your second interview transcript by initially chunking it into 10 meaning units which were each given a title capturing the theme of that unit. These 10 units were then chunked into the three core categories which constitute the lines of inquiry derived from my review of the literature. These are:

1. Experience of self (personal & professional) including how you experienced the research process;

2. Experience of therapeutic relationship (including your reflections on how your client experienced the relationship);

3. Experience of therapeutic practices and your perception of outcomes.

Of course, the naming and placing of these units into the different categories was a subjective process. Also they need to be read systemically, in that they are all interrelated.

In this way *your* analysis of the transcripts is given centre stage rather than the traditional analysis of text done by the principal researcher. (In part three of the thesis, I discuss the implications the research findings have for clinical and research practice). The headings are not placed in order of priority or importance. If you feel I misrepresent your views in any way, please let me know, so that I can revise the findings.

Experience of Self (Personal & Professional)

Working as a team is useful for the therapist

What stood out for you is how working in a team is "useful" for your professional development. You also realised "how much I take for granted" how well the team had worked, and that "a team doesn't always work that way". You felt you have been "really privileged" to have had the "opportunity to work in a way that suits clients" and that works as a "quality control" for you as a therapist. You also found that working in a team was also useful "as a way of developing, and not just getting stuck into some bad patterns".

I felt a bit uncomfortable about her saying nice things about me

Although you didn't have a problem with Jane "saying nice things about the team" you felt "a bit uncomfortable about her saying nice things about me". You would have "found it more interesting reading a transcript of somebody who'd found the process not as useful" this was because "I could have learnt a lot about perhaps what I could do better, or what I could do differently". With this particular transcript you found it hard to "pin down what could we as a team do to improve what we do".

I think the value for me was reflecting on the process

You were not "surprised" by what you read in the transcript because you had reflected on how it might have been for Jane in your own interview. Given you had done a lot of thinking about "how the process had worked" when it came to reading Jane's transcript it only confirmed what you already had thought about. Although you didn't discover much from reading the transcripts, you felt "the value for me was reflecting on the process, and reflecting how it might have been" [for Jane]. "I think by the time I'd reflected on the process and how the therapy session might have been for Jane, I think I wasn't surprised when I read the transcript ... So it wasn't that I didn't learn from her transcript, but the transcript really reflected the process that we'd already talked about".

In the first interview you "started to think of some things that I hadn't really thought of before ... about the process of therapy and how the team works. I think I learnt a lot from that and that was a really useful thing to do".

Experience of Therapeutic Relationship

Absolute respect for the client

You admire the way the other team member's work with absolute respect for their clients. When you last saw Michael White's work the thing that really stood out for you was "his absolute respect for the client no matter what they'd done or how they'd lived their lives". In conclusion you said, "I think … if that is what I try and achieve, then I think that's a really good thing to aim for".

Respectful of not just your client, but of their experience

When discussing with Jane how she experienced the therapeutic relationship she spoke about how she felt everyone participated, (including her son Paul, who was thrilled to be acknowledged by the team). She thought that "there was no one more expert than the other". You felt that was a good outcome, and a result of the ethic of absolute respect that you talked about. "If your respectful of not just your client, but of their experience, and of their ideas about how to tackle the problem" then hopefully that leads to such an outcome.

Experience of Therapeutic Practices and Outcomes

The team has an impact on the process and on the therapist and client

What stood out for you was how important the team was to both you and Jane. Even though the team "sits behind the screen" it has an impact on therapy process and the experience of both the therapist and client.

"It was nice to read she felt comfortable", and that she thought both you and the team "attended to Paul in the session". You said, "It was nice to hear her talk about how useful she found the team and the reflections and how she heard things she hadn't heard before. It was good that "she took away some things from that session" that "she still has in mind".

"... a range of different explanations ... that gave her a different perspective."
In our first interview together we had discussed the use of professional discourse in reflecting team conversations. The example we considered was "separation anxiety", an idea that had been introduced to Jane by the team discussion. You understood this as one explanation among many that were possible. I understood from our conversation that the team does not feel restrained from using ideas from professional discourse if they believe it may be helpful to the client: "... you can come up with a range of different explanations and the clients will, they will go with the one that makes most sense to them, even if it hasn't occurred to them before". For example, you "thought it was good that there was some news of difference for Jane. That there were some things we talked about like the separation anxiety that she hadn't considered before, and that sounded like that was quite a powerful thing" ... and "that gave her a different perspective on the problem."

Choose language that fits with the clients view
Even though you thought it was a helpful therapeutic practice to sometimes introduce ideas from professional discourse into reflecting team conversations, you put some conditions on this usage. You said when you draw "on some other sort of theory or

explanation, I think you only still do that if you think that's still going to fit with the clients view, or it's going to match with the client. I mean you're not going to use a language that is going to be unfamiliar to the client so that they're not going to know what you are talking about."

Sometimes it is very tempting to do some telling, instead of some asking

Sometimes when you've had trainees on placement who have joined the team for training purposes, you have noticed "they have been very tempted to get into some of that explaining and advice giving and lecturing". It can also be a bit of challenge for you as well! However, like you said in your first interview, working with a team keeps you more mindful of therapy as a questioning process.

It confirmed that there is a place for team work

In conclusion you said: "I think the things that stand out for me is how useful a team is, and how even though it is seen by some as a bit of a luxury, in some ways I think, well it's a useful thing, but it's useful for all sorts of reasons, and it's really useful for the client. And I'm really pleased that Jane found it a useful thing, and that was probably the thing I learnt the most about her transcript is that really I'd not talked to anybody about their reflections on either my work to such lengths, or read a transcript of such length, or their reflections on the team, and the way the team works so, that was a really useful thing because then it confirmed that there is a place for team work, and for reflecting team work, so that was a really good thing I think that's come out of this."

Regards,

Andrew.

3.   Debra and Danny

Debra is a middle aged white Australian woman, who is a sole parent of two teenage boys, Danny and Mick. I met with Debra first. Prior to therapy she was feeling desperate, describing her home life as "wild". Mick had just turned 14 at the time and he was the wild one. Danny was 17 at the time of the interview and was intending to start a TAFE college course. Mick declined to be interviewed.

3.1   Interview Setting/Process

Both Debra and Danny attended the agency together for their research interviews. I interviewed Debra first, using a tape recorder. The interview lasted approximately one hour and flowed easily. Danny's interview was also recorded and lasted approximately 20 minutes.

3.2   The Interview Summary

Expectations

Debra did not have any previous experience of therapy, but she hoped they could get some help to handle the conflict and "calm things down a bit". She hoped that the therapy would help them stop arguing and "all get along" together. Debra and her family had attended an initial assessment session a few years ago but they had been told "we weren't bad enough to get top priority help, so we were put at the bottom of the list" and then they were just "by-passed" and "left off". So it was not surprising that when I asked Debra about her expectations and preconceptions about seeing the family therapy team she replied:

... the expectations weren't that high anymore, I was very reluctant to believe

that anything could help ... no one seemed to want to help us, but it was a

pleasant change and surprise to come in and actually get a bit of help. It took

time and that's something I'm not very patient with, I expected a miracle to

happen there and then, but by this point I knew that time had to tell and I had

to work with the team to get any results (42-49).

First Session

I then moved on to discuss her experience of the first session, which had taken place

approximately 6 months prior to the research interview. Both Mick and Danny

attended this first session but Mick had refused to "participate". Debra experienced a

lot of frustration with this. She believed Mick was the one who needed the most help

and neither Debra nor the team could induce him to participate. She found it hard to

understand at the time that without Mick's participation anything could change for

the better: "all I could see was, what was the point in only two of us coming or one

of us coming, what good's that going to do?"

Experience of Self

However, a *significant outcome* of the first session was that Danny agreed to come

back: "Danny was a bit funny about it, but he came back he said basically to support

me". The other *significant outcome* of that first session was that Debra "backed off a

bit". She realised that "it was going to take time and patience" and knowing that "the

help was there" supported her making this change. It was "really reassuring"

because "I was desperate for someone to listen, and they did". Later, when reflecting

back on her initial frustrations with Mick, Debra said "I've realised since then you can't make people do what they don't want to do, and there's no point him being there if he doesn't want to be". This illustrated to me how much Debra embraced self-reflection, began to see herself as a patient person and developed her own understanding of the futility of trying to force people to change. She concluded by saying "I don't feel hopeless anymore, I feel like yeah, we're going to do it, its going to happen."

The Therapeutic Relationship

The support of the team became important to Debra. The feelings of hopelessness disappeared and were replaced with a belief that "we can do this, in time" with "persistence and patience" and with some "advice" from the team on "what direction I am taking and if I am doing the right thing". Similar to Jane, for Debra the team gave her a sense of "reassurance" and "confidence" in herself as a parent:

> I feel strong again for it, and they reaffirmed that all the way through. They always made sure that I was being reaffirmed as a person, and as mother, and my decisions, basically I felt backed up for once in my life. Normally you're supposed to have your family to do all that and these guys were helping me do that, cause my family were, they're good, but they couldn't give me the experience and understanding that these guys could, so yeah ... (154 – 160).

I then briefly explored how helpful Debra's extended family may have been during these difficult times with Mick. Debra has a younger sister, who backs her up, but again, it is the "professional reassurance" that makes the most difference to Debra.

So I then moved on to asking Debra to describe in more detail her experience of her relationship with the team members. I asked her if she felt she had a close relationship with the principal therapist (Andrew) or with the team:

> The team. Definitely the team. But I knew they were there the whole time they never hid anything from me, they were very open about it, and we reversed roles, so we weren't the ones always sitting out in the room being scrutinised. They ... asked us to go out in the room and we could watch and hear what they had to say and think ... (197 – 201).

We then explored the development of trust. Debra felt she was "probably a bit frightened, a bit worried, about what they were going to say and what they thought" to begin with. But because she was "feeling very hopeless and very helpless at the time" "anything was better than nothing" and "they were very positive about a lot of things" For example, Debra would talk about "Mick's doing this wrong and that wrong" and she would start to get "really upset and wound up about it" and the team would "basically just back me up and say yeah well that's the right thing to do." So Debra became very comfortable with the team and felt she was able to talk about whatever she wanted to talk about.

I asked her, did she feel that she had some say in what was talked about in the sessions: She though it was "pretty fair really". Andrew W would ask how they had been and what had been happening and then "once we started talking we'd didn't shut up, we'd just keep going and going and going, and at the end of it we'd always come out of it feeling a lot better!" I commented to Debra that it sounded like she

felt actually heard and listened to, like they understood. She agreed and I asked her how did they do that? She didn't know but "they did it well".

I continued to explore Debra's experience of the therapeutic relationship which at first "was a bit tense" because "you didn't know what they were thinking". Debra remembered crying a lot in the first session with Andrew W and to hear the reflections was like "Thank God, finally, somebody's hearing me!" So following the first session trust was established. We talked about how the reflecting team worked, and if Debra believed she received more help from listening to the team reflect or from the interview with the principal therapist or the total package: "I'd have to say it's a total package." Initially, Debra thought she would have said hearing the team reflect was the most powerful part of the session, but on reflection she felt the opportunity to talk and "get it out of your system" was just as important. So in a way the client receives the one-on-one experience gained from traditional therapy and the reflections are like an added bonus at the end. I asked Debra if she could describe the difference between speaking one-on-one to Andrew W and the difference in her experience when she was behind the screen listening to the team"

> They really listened, that made the difference ... all I could think of was, wow they really listened, they weren't overcritical on me, or Danny, or us as a family, they just listened, and maybe, they just made suggestions and they congratulated Danny, because he didn't thump Mick for six months. They got up and congratulated him and he was wrapped he was just so pleased that they got up acknowledged that, and little things like that go a long way,
>
> *They do?*

They sure do ... (got to watch the tears now) ... I'm a very emotional person, which makes it even worse too ... they the reflecting and just reaffirming that I'd done the right thing was good that really helps me (373-384)".

Another important aspect of this experience to Debra was how the team came across as down to earth real people. For example, Debra did not realise that:

Ros was a child psychiatrist ... they don't make a big song and dance about who they are or what profession they are, they are just there as part of the team and realising it now, that impresses me a lot because they weren't big noting themselves or anything so down to earth about everything

Did they share any of their personal selves or?

Not really but they did. Like I'd say Danny is learning to drive now because he's just got his licence ... and Andrew would go Oh gosh! You know basically ... we've all been there done that and we know what it's like...

So it sounds like they

They were but they weren't

They were very much persons and not, like they were professionals and that was reassuring on the one hand,

Yeah

but on the other hand, they were it feels like you really felt got to know them as individuals

Yeah I felt more than comfortable ... it was just Ros, and Carole and Andrew nothing, I didn't even think of them as professionals, oh I did, I knew they knew what they were doing but I didn't realise, that they were you know,

psychiatrists and all that stuff like, it was oh wow! Their communication and their ... comfortableness was really down to earth and I enjoyed it (391 – 414).

Experience of Therapeutic Practices and Outcomes

We then moved along to discuss the course of the therapy up until the time of the interview. Debra and Danny continued to attend therapy sessions without Mick. It was difficult going to begin with. They "had lots of tears" and they "got down to the nitty gritty of actually communicating, between Danny and I". They talked a lot about Mick and how Mick's behaviour was affecting everyone. However, this had the effect of bringing Debra and Danny closer through developing a mutual understanding. "It made us look at each other and respect each other at bit more". Danny and Debra worked together and sorted "things out". They looked at their arguments and "the way we were carrying on at each other". Although Debra and Danny's relationship "wasn't that bad" it "could have led from bad to worse", so the opening up of communication really helped as did the supportive and non-judgemental reflections from the team which Debra described as "constructive criticism". Debra really appreciated that and Danny "seemed to respect that also" so they started to get on together fairly well after that.

She found it really interesting that Danny actually listened. "The main thing was the fact that he wouldn't listen to me personally, he'd listen to everyone else, but then the team would reaffirm how I was feeling and the respect thing and all that ... we're a *lot closer now*, and we get along a lot better." Before Debra would never have believed "that without Mick there and him getting the help, (I suppose I was blaming

Mick a lot, and I shouldn't have been). I believed that if he wasn't there it wasn't going to work but it has."

Debra also grew more confident in setting boundaries for Mick and refusing to be intimidated by him. She had put her "foot down" and her "confidence" had come back. Now, "if I say no, I mean no". She was taking a strong stance against his violence and she was prepared to call the police if he started to damage things. It was not easy, and there were "lots of tears" but it was the necessary and right thing to do.

The team were a great support to Debra in helping her realise her beliefs were okay. She just needed the "reassurance and the confidence". Knowing whether she was "doing the right thing or the wrong thing" made a really make a big difference to Debra's faith in herself as a parent. She also believed the reflecting team sessions had been crucial in helping Danny to hear or see things from her "point of view". Even with Mick she now thought she was getting somewhere. I asked Debra if the team reflections helped her appreciate Danny's point of view as well. She replied "yes, I've backed off, I give him more respect, and I listen to them, him now in particular. Yeah, so, it's more of a respect thing and the communication thing is a big thing, like the listening you know." I wondered if the listening the team were doing also helped Debra and Danny to develop similar listening skills.

The interview finished with Debra telling me that Andrew W had told her that he thought they were doing really well. Debra was concerned this might mean that the relationship was going to be terminated and "I want to keep the door open even if

it's only once every six months I don't mind ... but I need to have that reassurance there." In conclusion, Debra thought the team was "super".

During the hour I had taken interviewing Debra, Danny had been patiently waiting outside for his turn. I invited him in and he sat down and smiled in an embarrassed way and I thanked him for coming. Like many young men, Danny wasn't as fluent as his mother, and sometimes I feel I overcompensated by talking too much during the interview! However, I quickly warmed to Danny and admired his honesty. In response to my first question about what was happening before coming to therapy he said: "Well, before I came here I was beating my brother up, really bad, about three times a day." He clarified, "not all the time but, you know, I didn't control my anger or nothing, I feel bad about it now but, I've been trying to fix it up. I know I done wrong". Danny's recollection of previous counselling experience was that "they didn't do nothing". So he had very low expectations: "I didn't think it'd do anything". I asked Danny what he thought about the first session: "It was alright – just started talking and that, about what was happening ... made me realise all the things, about how much I'd hurt my brother and that, mostly mentally sought of thing (28 – 30)."

Danny described how listening to his mother and brother talk helped him realise the need for change. I asked him about his experience of sitting behind the one-way screen and listening to the reflecting team:

It was different. Never done that before so...

You listened to what the team was saying?

Yeah.

Did it feel a bit weird?

Yeah, heaps weird.

Heaps weird.

Yes!

But weird in a good way, it wasn't a bad experience?

No.

It was a good experience?

I think it's done good, coming here done good, it's like since we started coming here since the first session, I haven't laid a finger on my brother or nothing.

Since, from the first session onwards?

It's been about seven months.

That's amazing!

So we don't fight anymore – we do a little bit but not quite full on …

(42 – 57).

I then went onto the next topic which was exploring how Danny felt about himself and his relationships with his mother and brother before attending therapy and had it changed in any way since attending therapy:

> Well, with my brother I didn't really care about him, had no respect for him, I
>
> didn't care what he thought or how he felt, I just belted him up...
>
> *So now you care about him?*
>
> Yeah.
>
> *Do you think that caring was there before as well?*

Yeah.

You just kinda lost contact with it?

Yeah.

So somehow coming here, put you back in touch with your caringness for your brother?

We talk heaps now.

You talk heaps now?

Yeah, we just talk about things like when Mum's not around, just me and him

Right.

I take him out ... (66 – 80).

I then enquired if Danny thought there had been any particular significant moments or turning points in the therapy process but he thought it was more of a gradual development: "I think it was bit by bit, we slowly got there and we still are getting there, it's getting better".

I then moved onto the topic of Danny's experience of the therapeutic relationship. Danny thought the team listened well to all parties without siding with any one. He felt he had a relationship with every member of the team.

I thought that one of the key themes that Danny took from the team reflections was the idea of him becoming a role model for his brother. He said the team reflections gave him "more ideas on how I can be a role model for my brother". I wondered if the idea of being a role model for his brother was a new idea for Danny or something that he'd thought about before. Danny thought that because he and his brother hadn't

"like had a father type figure, I'd sort of taken over that role" and on reflection Danny thought "I went too far with it." So he decided he was going to "be more of a brother rather than making him do things he doesn't wanna do" ... "if he doesn't wanna do it he doesn't have to". This seemed to parallel Debra's realisation about the futility of trying to force people to change.

I enquired into how Danny must have felt respect for the team and that it doesn't usually happen straight away. He agreed, saying "it took time". I asked how they built respect: "Listening and helping me put me in the right direction sort of thing". Danny liked that the team suggested ideas to them and what they could do to make it better: "I used to be heaps angry, anything I done I was just heaps angry at everything and now I've learnt to go out and do things like go fishing and that helps me not do it ... they gave me some ideas and that, kind of stuff." Danny also came up with his own ideas "like going camping a lot because it makes me relaxed."

Danny's relationship with his brother had improved out of sight since changing from a father figure to being more of a brother. However, another unexpected outcome for Danny was "I reckon me and Mum have become a bit closer. We talk a lot."

Finally, I asked Danny about the importance of his extended family. He thought it may have helped that his mother and her brother had recently started talking again, but on the whole he thought: "I think I've done it most myself really, that's what I think".

4.   Andrew Wood

Andrew started working at the agency in 1984. He became Regional Director in 1988. Andrew has always located his work in family systems theory and brief therapy models such as solution-focused therapy and the work of Milton Erickson. Andrew also was very active in the family therapy movement in South Australia during the 1980s. He has had a number of articles published in family therapy and social work journals.

4.1   Interview Setting/Process

I interviewed Andrew in his office using a tape recorder following my interviews with Debra and Danny. The interview lasted approximately one hour. I felt we were both relaxed during the interview and Andrew enjoyed the opportunity to reflect on his practice. The conversation flowed along easily. When I asked him at the end of the interview to comment about his experience of the interview he said "Kind of joyous, quite comfortable. It was an enjoyable experience, its good to reflect."

4.2   The First Research Letter

As with Carole, the following letter is my attempt to summarise the major themes that came out of my interview with Andrew. However, apart from this goal, I was hoping to give something back (as with therapeutic letters to clients) by documenting some of Andrew's knowledge and skills that he drew upon during his work with this family. It also gave me an opportunity to take back to Andrew an acknowledgement

of how conversing with him has contributed to my own work as a therapist (White, 1997, page 202).

19.04.03

Dear Andrew

Thank you for participating in the research project. I have really enjoyed working with you and I miss the opportunity for further conversations. However, it is good working closely with Carole and I learn a lot from her and I guess therefore your influence lives on indirectly!

Enclosed within is a transcript of your second interview which I hope you find of some interest. With therapy, as with research, we often would have done things differently with the benefit of hindsight. I have belatedly decided to write you a letter summarising some of the main themes we spoke about during your *first* interview. I wish I would have done this *before* I interviewed you the *second* time. The process of writing this letter has helped me to condense the material as well as stay within the collaborative spirit of my research methodology. It is also an accountability process. This letter together with your second interview, take the place of the traditional qualitative analysis stage of a research project carried out by a researcher with special skills. Given that I lack these special skills, I thought your own expertise could take their place! When you have finished reading this letter I would appreciate your feedback on would it have made it easier to have received a

letter like this before the second interview? Also, if you think I have misunderstood you in any way (isn't this inevitable?) please let me know.

The Process of Engagement

The story of your attempt to engage Mick and I guess invite him to shift from a visitor to a complainant to a customer was a major theme that comes up first in the interview. I liked your description of Mick hiding under his cap, and you say "I worked reasonably hard to connect with him and he, he you know was difficult to get much more than a yes or no out of him" ((59-61). I liked your ideas about how to go about engaging young men who have been compelled to attend therapy sessions:

1. Don't try too hard (you gave it about 10 minutes);

2. Acknowledge that you understand they don't want to be here and let them know that you respect that;

3. Express some curiosity about why they are here; and

4. Ask some closed questions;

5. Acknowledge that his/her experience with other counsellors may not have been all good. In fact you said to Mick:"you've talked to a lot of people, you must be sitting here thinking you know, 'god I've got to talk to someone else now, I've got to go through all this stuff again, and you people complain about me'".

6. Ask if there was anything that helped in the past;

7. Invite him/her to come back.

One of the learnings I have taken from this on-going conversation is how helpful the visitor – complainant – customer classification system can be as a tool or aid to the therapist. There is no point banging our head against a brick wall. I always have to remind myself although the conversation and relationship may influence the client, the client will change only if they want to change (as with Danny).

Feedback to the Family

Your faith in family systems theory is clearly a major belief system that informs your work. You said "I know that family members can have an impact on family members even if they are not involved". It was interesting that this view was certainly not shared by Debra at the commencement of treatment. However, over time, Debra came round to understand this also. So this shaped your feedback to the family which was:

> to Debra the team basically sympathised with her situation, particularly with Mick, that you know, maybe miracles weren't going to happen with him, but it was important that she maintained her own integrity as a person, and really how, what did she need to do, to go on trying to help Mick but also survive herself. So I think, in this team, one of the things we don't do is, we don't give people false hope, you know, I think, when I say we don't give people false hope I think we're realistic and ... when a situation looks pretty bad, usually at least one person on the reflecting team will basically will acknowledge that, and sometimes even embellish it (148 – 156).

Beyond Technique: Reflecting from the Heart

In reflecting on your reflections as a team, and how they have changed, I think you went on to make a significant comment on how the process of reflecting has changed for you. They are no longer "technique driven reflections". You said "I think we talk much more probably from the heart these days" (164-65). As the team has evolved you have all become more comfortable with "speaking our mind". Team members are also prepared to take risks and say things that some family members might find a "bit provocative". Or often you'll pre-empt that by saying something like "I want to say something that people might, the family might find a little strange, or a little challenging but this is what I think". This seems to remind me a little of an article written by Cecchin & Lane (1993) called *From Strategizing to Nonintervention: Toward Irreverence in Systemic Practice,* were they argue that a systemic therapist can be both strategic and collaborative (non-instrumental) – that it is not an either/or thing. What do you think? I wonder if you would agree with this following quote:

> Some might say that irreverence too closely resembles a technique, but those
>
> who perceive it as such miss the essence of the concept. Irreverence involves
>
> having regard for some concepts but not falling in love with them.
>
> Irreverence allows the therapist to avoid falling into the restrictive position of
>
> believing strongly and permanently in one model. The irreverent therapist,
>
> however, is not an eclectic. He/she can believe strongly in a model, or an
>
> idea, or hypothesis while being free to discard it when it is no longer useful
>
> (Cecchin & Lane, 1993, page 131).

This spirit of "irreverence" seems to characterise the way in which you and the team now work. For example you say:

> So I think what I've found the great thing about the team is the variation in opinions that there can be, differences of opinions or maybe different levels of optimism, or different suggestions but not everyone has to agree, and I think that's one of the problems with the way we used to use teams, is that everyone had to, you know the message was all the same, and terribly optimistic and um and it was a bit sort of pollyannish sometimes (173 – 178).

The Message from the Team to Danny

I really enjoyed both hearing about the way you worked with Danny and also hearing from Danny himself about his experience of therapy. It was quite remarkable that after that first session he determined he would no longer use force to get his brother to change. You also both agreed that one of the key messages relayed by the team to Danny (that fitted for Danny) was that as an older brother could he model a way of living for Mick. You thought giving the message that Danny was important (not just Mick) was one of the most helpful things that you did in the first session. Because the focus had always been on his brother, you were the first professionals to pay some attention to him and say look, "there's a chance you could show your brother the way, and he'd never thought about that before".

At the end of the session you said Danny declared 'I want to come back you know for myself'. I also thought in not attempting to persuade or convince Mick to come back you were also modelling this is the family. You were saying, not in words, to

both Debra and Danny, look, you can't force Mick to change. He has to want to do that himself.

The Message from the Team to Debra

I really liked how the team affirmed and validated Debra as a parent and how you thought "she was doing her best in a very difficult situation". I was also touched by your description of how Debra started to cry when Danny said that he would come back. My hypothesis is the team's invitation to Danny was instrumental in beginning this process of Danny and Debra moving closer together and both stepping back from trying to get Mick to change. However, they both took the indirect message that they could change.

The Therapeutic Relationship

You believed correctly the family experienced a relationship with all members of the team. The family also valued your absolute commitment to be there for them. I am sure that your reflecting from the heart not only influenced what you said but also how the family experienced you and the team as persons. I am sure this would have had an influence on the therapeutic relationship, the alliance and their experience of being understood or empathised with. Also, for both Debra and Danny, the importance of having you and the team there saying "good on you" like you said, cannot be underestimated. It was therefore very clear to me from the interview, that although the going was tough (trying to engage Mick), you really enjoyed working with Debra and Danny, and like you said: "I've seen them both change, I think that's, that's the great thing about this work".

So, thank you very much for sharing that Andrew. I hope that I can also bring some of your spirit of irreverence, reflect from the heart and connect with people in the way you did with Debra and Danny.

Kind regards, Andrew.

4.3   The Second Research Letter

20/01/04

Dear Andrew

I have decided to write you a letter, documenting what I am describing in my thesis as the "research findings" from your second interview. In this interview you were invited to comment and reflect on what stood out for you after reading the transcripts from both your own and your clients' first interview. This placed you in much the same position as the audience to a reflecting team, only reading (rather than listening to) the stories your clients and yourself told about their/your experience of the reflecting team. In this way our research practice parallels the process of a therapeutic reflecting team.

I "analysed" your second interview transcript by initially chunking it into 17 meaning units which were each given a title capturing the theme of that unit. These 17 units were then chunked into the three core categories which constitute the lines of inquiry of this research derived from my review of the literature. Of course, the naming and placing of these units into the different categories was a subjective process. Also they need to be read systemically, in that they are all interrelated.

In this way *your* analysis of the transcripts is given centre stage rather than the traditional analysis of text done by the principal researcher. (In part three of the

thesis I discuss the implications the research findings have for clinical and research practice). The headings are not placed in order of priority or importance. If you feel I misrepresent your views in any way, please let me know, so that I can revise the findings.

Experience of Self (Personal & Professional)

We have to be ourselves

Andrew, you spoke passionately on the importance of therapists being themselves, being genuine, on an experiential level: "we have to be true and not to try and be things that we're not". You commented that "at the end of the day I think that's what makes this work powerful".

You reflected on your experience from an historical point of view. How much has changed in twenty years, how team members were often anonymous, were a written message was given, delivered like a formal speech. It was an artificial, contrived and technique driven process that you are no longer comfortable with. You said, "looking back now, I shudder at some of the things we did!"

Andrew, you thought the best ally a therapist has when they feel "stuck" is to "fall back on their self" rather than search for a technical solution. To speak from the heart. In the first interview you said "I think we talk much more from the heart these days" and that the reflections are no longer "technique driven". Andrew, this seems to be a significant development in your work.

We sit with people in their pain

You also focused on the importance of working on an emotional level. You spoke of being able to "sit with people in their pain" without giving them false praise or hope. Therapy from this point of view is not always focused on emphasising strengths, or being falsely over-optimistic. You thought therapists need to have a capacity to manage the experience of being with people in their pain, without pretending to know or to have the answer or solution. You said, "I think on the team, I think we've learnt how to do that, I think individually and collectively we've learnt to do that over time, to be able to sit with very difficult situations, but not necessarily knowing the answers".

I asked you, how did sitting with the pain help Debra and her family and you thought "probably because we listened ... to each of their stories ... rather than rushing in and telling them what to do". After further discussion you thought, "if someone can sit with a client who can keep it together and not be overwhelmed ... to get to know those people and their experiences, aside from the problem if you like ... I think that is the task ... I think as a team, I guess you could call us a bit of a steadying influence."

Reflecting Team Practice as Live Supervision, Training and Research

You discussed some of benefits for *therapists* from working on a team: "For challenging cases, working on a team is a good use of resources because it provides a support network for therapists." For example, "you can debrief the experience ... in a way with a team that you can't do when you're on your own." You also feel that

working with a team is one of the best ways of learning therapy: "it provides you with ongoing training … we get our work developed all the time by what we do, we get challenged all the time, we challenge each other all the time …" We both agreed that it was like an ongoing research project.

The "other great thing about working as a team is it makes therapy a very transparent and public process" and therefore "I feel more accountable". However, you had concerns that this kind of practice was in danger of becoming sidelined, especially in the public sector, and how this would be a great loss of opportunity for professional development.

Experience of Therapeutic Relationship

Team members came across as persons, not professionals
I think this finding came across as very significant for you and was indeed very affirming of your belief as expressed above that it is important to be genuine. From your reading of the transcripts it did seem to support the view that when therapists communicate from their own experience as persons, rather than as professionals, it helps in the establishment of the therapeutic relationship:

"I think the thing that stood out for me, which was not surprising, but was affirming I think, was really her overall sense of the team as people who were straight with her and people who were honest, and I think that's what she wanted.

Debra stated that "they didn't big note themselves" after she had found out that one of the team members was a psychiatrist. Debra's comment was interesting to you because: "maybe I wasn't as aware of it, 'cause when I read it I was struck by that, it was almost as if she expected that we would do that, and that because we were professionals we would somehow be, you know, distant or aloof, or know everything, those sort of things. So I found that really refreshing. I think that also has to do with the fact that the three of us have worked together for so long, I think we're natural with people. We don't put on airs and graces, we don't put on airs and graces with each other; and I don't believe we do that with people, so that was good to hear."

Relationships between Team Members

Team members related to each with a sense of comfortableness that comes with years of working together and you thought (and hoped) that the feeling of comfortableness "spreads around to the family as well" feeding back into the therapeutic relationship a sense of comfort, trust and openness.

Team meeting was an Important Ritual

On reading the transcript you began to appreciate how the reflecting team meeting became "an important ritual" and "an important symbol" for Debra.

Team's communication was down to earth

Debra made it clear that she experienced the team's "communication" (way they talked) and "their comfortableness" as being "really down to earth" and she "enjoyed

it". You thought Debra was also referring here to the "openness" of the team's communications, and that she welcomed that.

Experience of Therapeutic Practices and Outcomes

Therapeutic Practices were tailored to fit the client

You describe the team as pluralistic in the sense that you are "not a slave to any theoretical model" and that following Erickson, "the approach should be tailored to the client". You have noticed in the team that you'll often take a different approach to different families. So for some you might do a lot of solution-focused work; for another family you might do more a Milan-style intervention and so on. In conclusion, you thought "we don't do anything in a pure form".

The Client is Resourceful

One of the main ideas you took from Erickson was "a view of the client as someone who is resourceful, someone who is genuinely doing the best that they can given the resources that they have". You also like Erickson's definition of the unconscious, which he described as a "vast storehouse of learning" and that has been really useful for you in your practice.

We don't give false hope

Debra found it helpful that the team "were straight with them" and that you didn't give "false hope" or "false praise". Reflecting on how teams use to work in the past you said "if you give people praise that they don't believe they're entitled to, they don't except it, or they argue against it, and I think that's one of the things that we

used to do in the earlier days of family therapy, was we used to go back with these glowing reports, and the families used to sit there, and they sometimes used to say, 'Well, I don't feel like that.' And we didn't really hear that."

Clients' felt heard, listened to and acknowledged

Both Debra and Danny confirmed the importance of feeling heard, listened to and acknowledged. You thought that was confirming of one of the "key ingredients of good therapy". Danny said: "The team listened, made suggestions, but didn't tell me what to do."

Suggestions can be effective

You pointed out that one of the main outcomes for Danny was that "he was no longer beating up his brother" and that was really pleasing to you:

"Also what was significant to him and really its interesting, some of the suggestions we make often might seem minor, but often for people they are not minor, and one of them was our suggestion to him, which was almost a throw away line at the end of the session from the team, that he could be a role model for his brother and that idea sort of stuck with him ... So that was a metaphor for him that sort of made sense at the time and developmentally seemed to make sense because he been this sought of father figure and it wasn't working for him".

Not all family members need to attend for relationship change

Andrew, this was a theme that you also touched on in your first interview, where you said, "I know that family members can have an impact on family members even if

they're not involved" (in the session). In the second interview you went on to expand on this:

"Other points from Debra's interview was the fact that she picked up on the point that it was significant to her that we continue to see them, even though Mick wouldn't come in. And, I got the sense from reading her interview that you know when he made it clear at the end of the first session that he wasn't going to come back, she may have been thinking "Oh we're not going to get anywhere here." But then when we said, "well, look even if he doesn't come in, we'll see the two of you", that was important to her; I think we were flexible around that. 'Cause I remember we had a very early sense, that look if we couldn't do anything for Mick, maybe we could do something for Danny. Not just for himself, but also in his relationship with his mum and his brother, so we really did follow that principle, really you know if you follow systems to its true word, then in a way maybe it doesn't matter who you've got in the room, that you'll still have an impact, even potentially over people who aren't even there, and I think that's actually happened, I mean just from reading their interviews there's a sense that certainly Danny's relationship with his brother has changed, and I think mum's relationship with Mick has changed, and Mum's relationship with Danny has changed, so in fact there has been some ripple effects there. So the fact that she saw that as significant that we were prepared to see them was important. And also that, she picked up on the fact that we were focusing, or part of the focus, was on her relationship with Danny, which she was maybe a little bit surprised by, because of the fact, that was not why she came in. She came in because of Mick, and yet we were talking to her about her relationship with Danny. So I think

I just had the sense from reading that transcript that she found that useful, but also wasn't expecting it …

The other really positive thing was her confirmation that the therapy had helped she and Danny improve their relationship, and she confirmed that, and that was really useful to hear, 'cause that was one of the things we wanted to do, 'cause we thought that if that could happen, if their relationship could improve, then how they dealt with Mick could also improve. And Danny hopefully could become more of a brother rather than this, more domineering father figure …

So its interesting, even though Mick came along once, it seems this therapy had some impact on Mick, well, we could hypothesise that it has some impact on Mick, the fact that his brother was going to be more of a brother to him and not beat him up and tell him off and so on, and for Debra there was some impact on her relationship with Mick as well …

I think the other significant thing was, for Danny … that came out of his transcript, was that we paid him attention and I don't believe he expected that, in fact I'm sure he didn't, because they came along with Mick and he was certainly at the centre of their attention because of his behaviour. So Danny I imagine expected to just come along and be fairly passive and not say much or not be asked much, so just from reading his transcript I suspect he was probably a bit surprised that he was paid attention, that we thought he could help his brother, and that we asked him back. Even though his brother, even though Mick didn't want to, we asked Danny to come back, and I think what that raises is, I think it just reminds us that, that's one of the

great things about family therapy is that you've got lots of people to work with, its not just the individual to work with, you've got lots of people you can call on, but also you know different family members who can also get benefits from therapy even though the therapy is not for them so to speak. And we find that all the time in the team."

The message sent isn't always the message received

"The other fascinating thing from her transcript was that, and this took me a bit by surprise, and it's a really good example of how we should never assume that what we think we're saying is what people hear; she thought that we were telling her that Danny should leave home ... We never said that, we would never tell people; 'Look really you've got to let him leave home, or you've got to leave home' em, but she thought that's what we were saying, so I was a bit, I was a bit, perturbed by that."

Debra then went on to say that she was less inclined to pressure him into staying, so when she backed off, then he decided he didn't want to leave. You agreed with this and said (laughing):

"That's exactly right! When you put it that way, it sounds like we orchestrated the whole thing, and we didn't. We never had any intention of....we never saw that he had to leave home, or that it was better for her to let him to leave home, anyway it would be very interesting to know, and I think what this raises is the incredible nuances in the language that we use, I mean, there's something that we must have said, or conveyed in such a way for her to believe that's what we were saying ... so

it's a good example of how, you know the message sent isn't always the message received."

Team reflections were remembered more by clients

"The other significant thing from Debra was that the team feedback was most important to her, and I'm not surprised to hear that. That was more important to her than what she and I talked about, because as soon as we were coming up to a break, her energy, she'd suddenly get quite excited, and she'd be just busting to hear what they were going to say. And the feedback, she made the point that the feedback helped her to not feel hopeless, so in some way we... 'cause certainly when she came in she was feeling hopeless, so I think we tried to address that."

Debra takes a stand

This also was another theme that you had discussed in the first interview, where you commented: "to Debra the team basically sympathised with her situation, particularly with Mick, that you know, maybe miracles weren't going to happen with him, but it was important that she maintained her own integrity as a person, and really how, what she needed to was to go on trying to help Mick but also survive herself."

After you read the transcripts you thought "that there's a real sense now, she's not so much of a slave to Mick's behaviour. Certainly when she came in she felt like a slave to the things that he did, I think there's less of a sense of that... that she had a life as well , she couldn't save him from everything that he was doing, so that was good to hear."

We also talked about how the team reflections assisted Debra maintaining her own integrity as a person and parent, not only with Mick, but to survive herself, to have a life of her own. For example, in your first interview you said: "When we first started with them I think she was very guilty, I think she thought that she was responsible for what this boy was doing. I think now I think that shifted I think she gives the impression now that she feels a little bit more liberated from that sort of idea that she's to blame". I thought that was a big movement for her. You said: "And that has to have an impact on her dealings with him. If she is less paralysed in that way, it's more likely that she is going to be able to deal with him."

Noticing how change is embodied

My last question was, and I guess you could write a book about this, what is it that we notice as therapists when we speak about somebody changing, what is it that we are witnessing what is it that we notice? You replied, "When people change, well people can change in lots of different ways." I suggested you think in terms of Debra and Danny. "Well I noticed from what they said, but I also noticed from even the way they looked. I can remember say, you know, the second subsequent sessions compared to the first she looked less burdened, and often you notice that with people is that they actually look physically different." This led me to say I believe our conversations are always embodied. I find the distinction between language and body language less than helpful. You agreed with this: "Absolutely, absolutely. So, I've certainly noticed that, even with Danny, he became more talkative, he became much more talkative."

Regards, Andrew.

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CHAPTER FIVE: IMPLICATIONS FOR PRACTICE

1.   Introduction

In this final chapter I reflect on the implications for my own clinical and research

practice of the findings presented in chapter four. I also relate some of the findings

back to the research literature discussed in chapter one. I speak from the position of

a narrative practitioner-researcher. This inevitably involves me extending the

research conversation by making interpretations from a narrative perspective, in my

own attempt to understand the implications of what the participants had to say:

> Conversation is a process of coming to an understanding. Thus it belongs to
>
> every true conversation that each person opens him to the other, truly accepts
>
> his point of view as valid and transposes him into the other to such an extent
>
> that he understands not the particular individual but what he says ...
>
> Understanding and interpretation are ultimately the same thing (Gadamer,
>
> 2001/1975, page 385-388).

This chapter is therefore another extension of the research conversation, as

therapeutic letters are extensions of a therapeutic conversation. In choosing to focus

on how reading the transcripts impacted on my own practice, I am speaking as if I

was on a reflecting team. While writing this chapter I followed a similar method to

that recommended by White (2004) in relation to outsider-witness practices. I focused my attention on:

1. The particular written expressions I was drawn towards;

2. The images and associations evoked by those expressions;

3. What in my own experience resonated with these associations and images; and

4. How being an audience (and reader) of these stories and then reflecting on them myself, affected me as a practitioner-researcher.

The reflections follow the same structure in which the findings were organised:

1. Becoming a client (client expectations);

2. Experience of self;

3. Experience of the therapeutic relationship; and

4. Experience of outcomes and therapeutic practices.

It was assumed the clients' experience of each of these domains contributed to their experience of outcomes. When assessing the benefits of participating in family therapy I agree with Hoffman that it is important to distinguish the kind of outcomes that are experienced in family therapy from the notion of a "cure" in the medical model:

Whatever the situation, it seemed that what we were dealing with was unfathomable emotions or unexplained behaviours, and that our main job had

to do with relieving fear, dispelling confusion, and restoring hope. That was the big difference between us and the physicians. They could prescribe medications, which sometimes work wonderfully, but the relational therapies needed a lexicon that was not necessarily based on change (Hoffman, 2002, page 257).

The experience of restored hope for example, was an outcome that both Jane and Debra reported as being related to both their experience of self, the therapeutic relationship and various therapeutic practices. Finally, I do not attempt to reflect on the expressions of each participant in each domain. It follows that my reflections are selective and illustrative of each domain only. It would have been possible to have included the reflections of other practitioners, who would no doubt have selected different expressions that resonated with their own concerns as practitioner-researchers.[12]

2.   Clinical Implications

2.1   Becoming a Client (Client Expectations)

The experience of becoming a client was concerned with the expectations or preconceptions that a client brings with them into the therapeutic process and how these expectations may affect their experience of therapy. These expectations may help or hinder the process of therapy. It may be the case that unspoken cultural assumptions or that previous experience with other counsellors are shaping clients' expectations.

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[12] When presenting the findings of decentred research at a conference venue it would be in keeping with the practice to encourage the audience to share their own reflections on the findings. This would be another example of how the research conversation could be extended to a wider audience.

Jane began her interview with the statement that she was expecting some kind of "guidance and direction" and some "tools and techniques". In my own practice I find this is a common assumption. Its strength comes from the experience most people have of medicine and other helping professions which assume therapy is a one way process with the therapist centred as the person who will guide the client and give them strategies that will help them. I am not saying that this is not always helpful and sometimes clients can be disappointed if these expectations are not met. Neither is it that different from narrative therapy, where the conversational skills of the therapist are used to enable the client to access their own knowledges and skills (White, 2004). However, it reminded me of how important it is to inquire into client expectations and to give the client some understanding of how I practice as a therapist.

Another interesting aspect of Jane's interview was her self-report of feeling somewhat anxious before attending therapy because she was concerned that the therapist wouldn't see the problem as being serious enough. This served to remind me, how for many clients coming to a therapy session is not always an easy step. Therefore, how important it is to put them at ease and validate their concerns that led them to seek help in the first place.

In contrast to Jane, both Debra and Danny had low expectations of therapy (and Mick obviously had other things on his mind!). Hence the team had to work harder to engage the family. They succeeded with Debra and Danny but Mick refused to change his mind. Again, this reminded me of the need to spend some time exploring

clients' experience of previous helpers and how this might affect my ability to engage clients. Also, some family members (who are usually attending against their better judgement) will never become customers because they have already decided prior to attending therapy that they will resist this outcome.

2.2   *Experience of Self*

The participants' experience of self is concerned with how the process of participating in therapy (as client or therapist) influenced their experience of self. Much of the literature I reviewed on reflecting team process focused on how clients experienced changes in the domain of self. This often took the form of gaining a new perspective on themselves and their situation from listening to team reflections. From a narrative perspective, this usually involves the client positioning themselves in an alternative narrative of self as an outcome of responding to therapeutic questions or team reflections. This then leads to a different *experience* of self. However, the literature has tended to neglect the parallel experience of therapists. The conversation I had with Andrew Wood brought my attention to how the therapist experiences self in response to the stories they hear in therapy. In particular, he described finding out about the importance of "being himself" and being able to "sit with people in their pain and be able to manage it". In this way Andrew turned the focus back onto the subjectivity of the therapist.

Andrew's discussion of these issues reverberated with my own experience as a therapist. During moments of silence when I have been unable or unwilling to respond with a question I had to sit with my own feelings of inadequacy in response to people in intense pain. It brought to mind a family I worked with who had lost

their eldest son in a motor vehicle accident. The father's pain seemed almost unbearable in its heaviness. How could I lighten his load? By being true to myself? By sitting with his pain and sharing the load? Andrew says repeatedly you have to be true to yourself. But what is the self? What is being true?

I think what he meant by this was the importance of being honest. In fact he stated that what was affirming about his reading of Debra's interview was "her overall sense of the team as people who were straight with her, and people who were honest, and I think that's what she wanted." Andrew also emphasised the importance of not giving "false" hope or praise, in other words, speaking truly.

This started me thinking about the meaning of being true to my self as a narrative therapist. Since my first experience of reflecting teams at Dulwich Centre in 1996, I have always been struck by how close the experience is to theatre. When I was sitting behind the screen as an audience (or outside-witness) to the client's story, I was keenly aware of the dramatic potential of what I was witnessing and experiencing. However, Andrew's discussion helped me realise that the therapist, like the client, is also a performer when in front of the screen. This also seemed to fit with the notion of therapy being a two-way process. The therapist is open to change on an equal footing to the client. The therapist's performance of meaning is authenticated by the audience in the same way as is the clients. This reminded me of my own experience of being a member of a reflecting team when I would find myself reflecting on my own experiences with significant people from my own life. Sometimes being a member of a reflecting team could be just as much a

transformative experience for a team member as it was for the person who was consulting the team.

Andrew's reflections also alerted me to the importance of *embodying* my experience. It's not just *what* I say that counts but *how* I say it. The affective tone and posture of how I say something will communicate if my emotional response is embodied (present) or if I am mechanically just going through the motions (absent). Another word often used in narrative practice to illustrate this distinction is emotional *resonance* (White, 2004). Clients' stories resonate with our own lives, our own personal stories and touch us in ways that can never be predicted. Andrew reminded me that as an actor performing (or bearing witness) I have to be true and genuine.

2.3 *Experience of the Therapeutic Relationship*

The clients' (and therapists') experience of the therapeutic relationship (alliance) is increasingly being recognised as a key factor in family therapy (Flaskas, 1997, 2002; Gaddis 2002; Pocock, 1997; Martin & Allison, 1993). However, the experience of the therapeutic relationship within the unique context of reflecting teams has received less attention. This includes attention to the relationship between the members of the team as well as between the clients and the team. I was particularly curious if clients would experience a closer relationship with the index therapist or with the whole team. Having experienced working with a number of different people in a reflecting format, I was also drawn to what the research participants said about their perceptions of the relationship between members of the team.

After reading the transcripts it seemed to me that a reflecting team of three people was an ideal number. It allowed the team to develop a close working relationship and allowed the clients to feel as if they had a relationship with each member of the team. It struck me how important it was to Jane, Debra and Danny that they could relate to the team members as people. How the expression "down to earth" seemed to encapsulate this experience for Debra. She felt she really "got to know them as individuals".

As discussed in chapter one, the client's perception of the therapist is an important determinant in shaping outcomes. Clients need to feel comfortable with their therapists. Jane described her relationship with Carole and the team as comfortable, open and honest. She felt a good rapport and personal contact with the team. She felt she could laugh and talk about things that were not related to why she was there. A member of the team did some personal disclosure which was helpful because "you saw that they were just ordinary human beings too, people that have problems … that are parents and didn't have perfect angels either". In the same way Debra was impressed by the fact that the team didn't "make a big song and dance about who they are or what profession they are". Locating oneself as a person with a life outside of one's professional self therefore seemed to be a key factor in establishing connection and trust.

However, I guess it took me a little by surprise that the knowledge that the team members were also experienced professionals was very important to both Jane and Debra. They both voiced the viewpoint that professional help was a necessary alternative to help from friends and family. It seemed that the team members were

able to strike a balance between the professional and the personal in a way that resonated with their clients. This was something I had not previously considered, that I would be positioned in a discourse about professionals that was part of the expectations and preconceptions that clients bring to the encounter. (I must say that in some cases those preconceptions are not always as flattering). But again, it highlighted to me the importance of trying to deconstruct my professional status within the process of establishing a relationship by discussing how I work and what their previous experience of professionals has been like. In this way I can emphasise the importance that I attach to some skills (therapeutic conversations) as against other skills (psychological diagnosis) in the early stages of the therapy process. This also fits with always recognising the power relationship between client and therapist.

The positive therapeutic effects of the experience of feeling understood have been found in all kinds of therapies, but the place of feeling understood in family therapy has often been a neglected topic, with some exceptions (Perry, 1993; Pocock, 1997; Flaskas, 1989, 2002). Jane's experience seemed to confirm the importance of being heard and understood. She also experienced a sense of the "burden" being "shared". The weight had been taken off her shoulders! Just knowing that there was someone there supporting and validating her parenting enabled her to parent Paul with a renewed sense of optimism. She wasn't given any extra strategies but she started to notice some outcomes which fitted with an alternative story of her parenting. She observed that when Paul was going "off the deep end" she was able to "remain calm". As a result of this Paul's tantrums didn't last as long because she was able to remain calm.

Before Jane attended therapy it felt like it was "all too hard" and she couldn't do it [parent] any more. She was also feeling depressed and had started taking medication. In sum, she felt she was "sinking". After the first session she felt reassured there was somebody else to support her:

> ... after the session I guess I felt a bit uplifted, as I said I felt quite relieved ... having made a move to get help I felt as though the responsibility wasn't all mine, that I could offload a bit ...

Jane's son, Paul, also left the first session beaming, following a reflection which commented favourably on his participation. So, although Jane did not come away with any tools or techniques, she felt the team had demonstrated a "good understanding of the situation" and she left the first session with a "feeling of hope".

This experience of reassurance, of the team *being there* for the client was also echoed in Debra's comments. For Debra it was also important that the "help was there" and the commitment from the team "was really reassuring because I was desperate for someone to listen, and they did". The reassurance and validation of her parenting stance that Debra received from the team gave her an increasing sense of confidence as a parent: "they always made sure that I was being reaffirmed as a person, and as a mother, and my decisions, basically I felt backed up for once in my life".

Perhaps one of the most significant outcomes from the work with Debra and Danny was Danny's agreement to come back again after the first session. It seemed to me that the successful engagement of Danny was the turning point in therapy with this

family. Following on from this Danny and Debra reclaimed their relationship and Danny started to relate to his brother in a more brotherly way. For Andrew Wood, this reaffirmed for him the strength of family therapy: that not all members of the family need be present and that it only takes one member to change to affect all other members of the family.

The therapists' experience of the therapeutic relationship (and their experience of working with colleagues in a team) has been relatively neglected in the literature. It seemed to me that one implication for future clinical practice was the importance of team members working together consistently for a long period of time, or at least having a common understanding of therapeutic practices. In this instance, both Andrew and Carole made reference to the importance of the development of trust and mutual understanding between colleagues. The team then begins to operate more as a team than a collection of individuals. The result being that therapists feel less self-conscious and less worried about making mistakes. Also Carole spoke about the ability to tolerate differences of opinion:

> ... because we've been working together for a long time ... I feel quite confident ... about what they are going to say, even if we have a difference of opinion, it is going to be OK, it's not going to be disrespectful or interrupt the therapeutic process or undermine my role in it ... I think that just comes with working together for a long time and having confidence in each others abilities (271-276).

It also seemed to me that the comfortableness the team members had with each other had an impact upon the clients observing the team. I think this helped to create the "down to earth" effect that all the clients commented upon.

2.4 Experience of Outcomes (Therapeutic Practices)

This section focuses on the participants' experience of various therapeutic processes and practices, in particular their experience of reflecting conversations and the process of swapping places with the team.

Jane reported her experience of swapping places with the reflecting team was quite unique. She felt like she was able to:

> Move away from it personally ... like stepping outside of myself, like you could see it from a different perspective or angle, and I actually heard, because they weren't speaking to me.

Both Debra and Danny also commented on the uniqueness of the team process. Debra commented on how the process of swapping places was central to creating the relationship with the team rather than with the index therapist alone. She also felt the process made a significant contribution to helping Danny see things from her point of view and also promoted Debra's understanding of Danny's point of view. These comments by the participants seemed to support the idea that the process of listening to the team's reflections aided the development of mutual understanding and respect. Danny described how listening to the team helped him to realise he could change the

way he was relating to his brother. Even though it felt "weird" it helped Danny to "realise all the things, about how much I'd hurt my brother".

Jane made reference to a number of specific reflections made by team members that had a therapeutic outcome for her. For example, the team made reference to how her own mental health (depression) would impact upon her parenting. This helped clarify this problem for Jane which she may have been avoiding. Jane said "that was something I sort of knew but I didn't acknowledge it but it became so much clearer having heard it coming from the professionals". This also served to remind me of the enormous power we wield as "professionals" given we live a culture which promotes the expertise of professionals over lay persons. Another team member made reference to the possibility that Paul may be suffering from separation anxiety. Jane had never considered this before and she found this a very helpful way of understanding some of Paul's behaviour which, prior to therapy, she had been interpreting as his attempts to control her.

Danny also made optimal use of a reflection (which Andrew Wood remembered as a "throw away line") suggesting that he could become a role model for his brother rather than a father figure. This possibility seemed to be a turning point for Danny which opened up new possibilities for him and his brother. Rather than "making him do things" he didn't want to do, Danny now cared for him as a brother and the outcome was they now talked "heaps".

The importance of staying with the problem and not generating a false sense of hope has a number of clinical implications, especially for new practitioners of family

therapy who may have read or attended limited training in solution-focused or narrative therapy. The fact that clients can experience moving too quickly away from their pain or the problem saturated story as disrespectful is a timely reminder about the importance of empathy and pacing.

2.5 Implications for Agencies

At the end of my interview with Debra I asked her if she had anything else she would like to say. This is what she said:

> Could I have done with this help ten years ago? Definitely! These guys should have been here for me ten years ago, I would not have got to the critical point with my kids I don't believe. I think there should be more funds or services for these guys, these sought of groups, TO PREVENT, rather than get to the critical point, and I, that's why I set the motion, the wheels in motion ten years ago, or however long ago it was, because I knew it would get to this critical point, and until it got to critical point there's no help. Because there's not the funds or the availability of this sought of service around until it's critical or desperate, so if there was more of it we'd all be a happier bunch, I think. That's my opinion anyway! (Laughs).

Andrew Wood also shares his concerns as follows: "I think working as a team is one of the best ways of learning this work, and it bothers me that we're doing less of it, it bothers me that we're making it less available to new staff, it bothers me that we're using it less and less for supervision ..."

Reflecting teams have enormous potential to both offer immediate services for desperate families and hence reduce public sector waiting lists. At the same time they provide excellent opportunities for ongoing peer supervision, yet, on the basis of my own experience, and anecdotal evidence, they are not being utilised in public agencies.

3. Research Implications

3.1 Distinguishing Research from Supervision and Therapy Conversations

How to distinguish research conversations from therapeutic and supervision conversations was a question that came up throughout my involvement in the research process. I think it is an important question because a research conversation can so easily become a therapeutic conversation and this is problematic from a research ethics point of view.

As I progressed into the interviewing phase of the research process I began to reflect on how research interviews both resembled and yet differed from therapeutic interviews. There are many similarities. For example, "research can be seen as an intervention into a system, in so far as the very questions we ask in trying to understand a group or culture create possibilities for change in that group" (Steier, 1991, page 178). Both are different to naturally occurring conversations in that they are more formalised and the participants meet together for a specific purpose. It therefore seemed difficult to distinguish them, especially when the research interview was about a client's experience of therapy. However, I came to the conclusion that

although therapeutic and research interviews share many commonalities there are some significant differences. For example, the therapeutic interview is initiated at the request of the client whereas the research interview is initiated by the practitioner/researcher. Secondly, the intention of the therapeutic interview is to be of some help to the client, whereas the intention of the research interview is the production of knowledge or understanding which may be of no benefit to the participant. In fact, people volunteered for the research in order to "give back" or help someone else. Finally, there are different ethical constraints because of these differences in context and intention. Thus, it may be implied in the therapeutic contract that the therapist can challenge the self understanding of the client; however, this would normally not be the case with research interviewees (Kvale, 1999). This implies being with the client in a different way depending on your intentions as either therapist or researcher:

> In a therapeutic session between a therapist and clients, the focus is on how the clients might be-in-the-world differently. In this co-research process, however, the therapists' focus was on how they might be-in-the-world-as-therapists differently (Andersen, 1997, page 129).

I therefore sought to separate my research conversations from the therapy conversations and this became a guiding principle in my research. For example, I did not write my research findings letters in the same way as I write therapeutic letters. Therapeutic letters are not just a summary of what was said in a therapy session. The therapist is conscious of searching for unique outcomes and metaphors as possible lines of inquiry into re-authoring conversations. Because my relationship

to the research participants was not that of a supervisor or therapist, I did not see it as appropriate for me to enter into re-authoring conversations around their professional identity, but rather to try and come to an understanding of what was said. I therefore took an ethical position to distinguish research from therapy conversations.

However, I can appreciate how easy it would be for these boundaries to slide. For example, even attempting to understand what was said may prove to have a therapeutic effect. Also, I think it would be a legitimate position to combine research and therapy conversations if this was agreed to by all participants. I think this would be the case if the researcher and the therapist where one and the same person. I could see how research conversations could transform into therapy or supervision conversations with the consent of the participants. I can also appreciate how narrative therapy conversations can be framed as a form of re-search (Bird, 2000). However, I was clear that for this particular research project I did not have consent to do this.

3.2   *Research as Personal and Professional Transformation*

Through engaging in this research project I discovered that research, like therapy, is a reflexive, two-way process. The documentation of research in academic journals is currently dominated by one-way accounts of the research process in which the subjectivity of the researcher and the voices of the research subjects are excluded from the presentation of the "results". Decentred research seeks to develop a two way account of the research process.

The act of engaging in this research project taught me how reflexivity worked on a personal level, as well as inviting the research participants to interpret the "data". It disclosed to me the intimate relationship between therapy, research and (self) supervision. The primary level at which reflexivity worked was on a personal level. Entering into dialogue with persons in their respective roles as clients/therapists and then with texts, required me to reflect on my own horizon of understanding. It also showed me how decentred research, like narrative therapy can be experienced as a two-way process. How the act of doing research (like supervision and teaching) in turn invited me to re-story my professional identity as a practitioner researcher committed to developing a research design which fitted with my therapy practice (Winslade, 2002).

One of the discoveries of doing research has been the realisation that it inevitably transforms. The ongoing internal dialogue, the endless sleepless nights, leads inevitably to a crisis point and then a resolution. As I entered my fourth year of the journey this crisis turned ineluctably on my professional identity. I felt on a personal level that the radical days of family therapy seemed to be fading away and I felt that the medical model was tightening its grip on the child and adolescent mental health agencies I worked within. This was felt even more keenly when I moved in November 2002 from Adelaide in South Australia to the isolated regions of tropical north Queensland, where I found myself conforming to requirements to write up assessments in the medical model mode and growing further away from my narrative therapy roots. Fortunately, reading Lynn Hoffman's intimate history of family therapy fired my passion again and helped me realise that I needed to be more up front about by professional identity to both clients and colleagues. It left me in a

familiar dilemma: Is it possible to affect change from within? Or would I have to leave and work from without its narrow confines?

3.3   Therapist Experience of the Research

I hoped that one of the benefits to therapists of participating in the project would be the opportunity to reflect on their own practice and identify new knowledge and skills they were developing. In short, an opportunity to reflect back not just on their work with the family selected for this project, but also on their professional identity, including discussing how their personal and professional experiences of self were interdependent. I was excited to find that this indeed did happen. I thought that Andrew Wood's reflections on his use of self, on the freedom he was now experiencing to be himself within the context of therapeutic consultations a good example. I think reading the transcripts of his clients assisted Andrew to story his professional identity in this way.

3.4   Client Experience of the Research

Unlike the therapists, the involvement of persons in their role as clients was limited to participating in the interview and reading the transcript of the interview. I was very pleased when Carole's client, Jane made the following comments when asked what it was like to be interviewed:

> I guess its like an added session, added therapy, because you get too, its sought of like, for example when you send me a transcript of what went on and you read it it's the same sought of thing its like reading what has previously gone on its like going over, again it clarifies things, it refreshes

thoughts and ideas, that you know sometimes you know when you've got so many other things you put things away and you forget to re-look at them, so its it's another form of reflection and re-looking, you know opening the box and having another look! So yes it's good.

Again it illustrates how closely decentred research and narrative therapy practice are intertwined and how research conversations can have therapeutic effects. I think also all the clients appreciated the opportunity to give something back in the form of this research. They hoped that sharing this knowledge would be of benefit to therapists who may read this research.

This research would not have been possible without them, and quite frankly, it was because I wanted to honour the generosity of all my research participants in giving their time to participate in this project that helped get me through to the end. There was many a time when I felt like giving up the journey, and it was through remembering their commitment to give something back that helped me arrive at the conclusion: "now I know how to go on" (Hoffman, 2000, page 256-258).

3.5   *What I would have done differently in hindsight*

The research design was not worked out prior to embarking on the research; in fact, the research design was created as I went along. Now that I have arrived at a completed design I can look back and with the benefit of hindsight see things that I would have liked to have done differently. I would have liked to have completed my research letters a lot sooner after the interview with the therapist. This would have given immediate feedback to the therapist as with therapeutic letters to clients. In

retrospect I would have preferred for the persons who participated as clients to have authenticated the summaries of their research interviews. This was an oversight on my part.

I often wished in retrospect that I had made recordings of the therapy sessions that were discussed in this study. Following the brief interpersonal process recall method developed by Elliot (1986; 1988) I could then have identified the particular segments that clients perceived as helpful on the recording. I could then have shown these to the participants and gained a richer description of their experience.

The process of opportunistic sampling, whereby therapists were invited to select their participants, delivered participants who enthusiastically endorsed their experience of therapy. In hindsight, Carole reflected in her second interview that she would have found it more interesting "reading a transcript of somebody who'd found the process not as useful … I could have learnt a lot about perhaps what I could do better, or what I could do differently". If I was to replicate the research design in the future I could alert therapists to this possibility. For example, I could ask them to consider inviting persons who have consulted them for therapy who may not have found all aspects of the process helpful. Alternatively, the research design could be changed to reflect a more targeted sampling process that would pick out families that were unhappy with some aspects of the process of therapy.

3.6   Critique of Decentred Research

As with any research methodology, decentred research has its difficulties and limitations. Firstly, clearly there is no basis for generalisation from the research

findings and hence they could not be used to justify policy decisions or argue that one form of therapy is more efficient or effective than another. It does not claim to provide evidence for practice claims. The understandings presented in decentred research will either enrich the understandings practitioners already have or they will not. Secondly, it is difficult to find the right balance between including the self of the principal researcher and the voice of the participants. Given that decentred research is a subjective, two-way process (affecting all participants) one possible danger is that the research can become overly *centred* on the principal researcher (the writer) to the detriment of the participants. The act of writing gives the principal researcher enormous influence over the construction and content of the text. Therefore this is a balancing act that requires the principal researcher to be mindful of this danger in much the same way as a therapist needs to be mindful not to centre themselves when giving reflections in a reflecting process (White, 1997).

3.7   *Suggestions for Future Research*

There is a lot to do. For example, in the area of the production of 'truths' about peoples' experience of therapy, 'evaluation' of the 'outcome' of therapy services is crucial. The politics of truth production have real effects on the funding of services. I would like to see more evaluation studies that are congruent with narrative and social constructionist ethics and assumptions. I would argue that evaluation processes are integral to therapy and are an extension of the therapeutic conversation. What's more, evaluation conversations are a crucial part of narrative therapy conversations in which therapists invite people take up agentive subject positions, and were they are given the opportunity to perform new identities or bear witness to others preferred identities. This is in contrast to psychometric outcome measures, in which

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therapeutic efficacy is often sacrificed for the sake of categorisation. I would also

give serious consideration to combining any future interview based research with a

parallel analysis of the transcript of the therapy session (Gale & Newfield, 1992;

Kogan & Gale, 1997; Gale, 2000; McLeod & Balamoutsou, 1996; Grafanaki &

McLeod, 1999). In this way an analysis of discursive positioning (Davies & Harre,

1990) could be set side by side with the participants own understandings of what was

helpful or hindering about the session. It is my hope that my professional identity as

counsellor and practitioner researcher will continue to be enriched by working in

collaboration with others in this way in the future.

4.   Conclusion

Four long years of researching! What an adventure, there and back again!

Like all adventures, it was not always easy sailing. There were times when I felt like

I was shipwrecked for good and there where times when I felt like hiding away on a

desert island never to be seen again. Now that the journey has come to an end, it is

almost difficult to say goodbye. I believe the journey has been worthwhile on a

personal level and I also believe it was beneficial to my co-researchers. I have

summarised what I believe were the benefits to the clients and therapist who

participated above, so I will devote these concluding comments to the benefits that I

have gained from participating in this project.

Firstly, I became acquainted with some of the contributors to the massive field of

counselling and psychotherapy research. I believe this is an invaluable process of

knowledge acquisition for any practising therapist. Secondly, I believe it is crucial to

develop research methodologies that are both congruent with ones own therapeutic orientation and produce research reports that both are relevant and interesting to read. I believe I have accomplished this objective and will continue to mine the rich resource of alternative research methods that are out there. Thirdly, it was a privilege to interview persons about their experience of being the clients of other therapists. This was an opportunity that is rarely experienced otherwise, and I am grateful to Jane, Debra and Danny for caring enough about others to give of their time in such a generous way. Fourthly, the partnership that I forged with Andrew and Carole continues to inform and enrich my work. The opportunity to interview therapists with more experience than ones self is an opportunity rarely experienced. I really enjoyed doing the interviews and listening to them. The relationships that were formed from our collaboration together continue to this day, and has meant a great deal to me.

For me, writing a thesis has been like the completion of my "apprenticeship" as a therapist. I believe through writing a thesis I have given myself the knowledge and skills to be a reflective practitioner, capable of doing self-supervision. I also look forward to doing more practitioner research and in particular, continuing to consult with my clients on a regular basis about what they found helpful.

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APPENDIX ONE: INTERVIEW GUIDES

INTERVIEW SCHEDULE - CLIENT

1. **CLIENTS EXPERIENCE PRIOR TO CONTACTING THE AGENCY**

   - What led up to you contacting the agency?

   - Had you any previous experience of therapy?

   - What preconceptions did you have of therapy?

   - What were your hopes and expectations about attending therapy?

2. **CLIENTS EXPERIENCE OF THE AGENCY CONTEXT**

   - How did you experience your initial contact with the agency?

   - Did you notice any changes between the time you made the appointment and your first session?

   - How did you find the agency environment?

3. **CLIENTS EXPERIENCE OF THE FIRST SESSION**

   - How did you find the first session?

   - How did you feel during the first session?

   - How did you feel at the end of the first session?

   - What was most helpful about the first session?

   - What was least helpful about the first session?

   - Did you share any of these feelings with the therapist?

4.   CLIENTS EXPERIENCE OF SELF AND RELATIONSHIPS

- How were you feeling and thinking about yourself and your relationships before coming to therapy?

- How are you feeling and thinking about yourself and your relationships now?

- Can you remember any significant moments during therapy, where your sense of self changed in some way?

- Can you remember any significant moments during therapy, where your sense of other people changed in someway?

5.   CLIENTS EXPERIENCE OF THE THERAPEUTIC RELATIONSHIP

- How did your relationship with the therapist develop?

- How significant was the relationship to the outcomes of therapy?

- What did you like/dislike about the therapist?

- Did you feel listened too and understood?

- If you felt misunderstood, where you able to talk about it with your therapist?

- Did you feel you were in charge of the therapy or did you feel the therapist was in charge?

- Did you feel like the expert on your own experience or did you feel the therapist was the expert on you?

- Did you feel your goals and topics of interest were followed by the therapist? Did the therapist follow your lead?

- Did you feel a sense of connection with the therapist? What helped you to develop this sense of connection?

- Did you share any of this with the therapist?

6.   CLIENTS EXPERIENCE OF OUTCOMES
      (THERAPEUTIC PRACTICES)

- What events or aspects of the therapy process did you find most significant or helpful?

- What events or aspects of the therapy process did you find least helpful?

- Did you share any of this with the therapist?

INTERVIEW SCHEDULE - THERAPIST

1. THERAPIST'S EXPERIENCE PRIOR TO MEETING THE CLIENT

- Please explain how you came to be working with this client?

- Did you have any preconceptions of the client (including problem formulation) before the first session?

2. THERAPIST'S EXPERIENCE OF THE FIRST SESSION

- How did you find the first session?

- How did you feel during the first session?

- How did you feel at the end of the first session?

- What was most helpful about the first session?

- What was least helpful about the first session?

- Did you share any of this with the client?

3. THERAPIST'S EXPERIENCE AND USE OF SELF

- How would you describe your experience of self during therapy?
- How did this influence your participation in the therapy?

4. THERAPISTS EXPERIENCE OF THE THERAPEUTIC RELATIONSHIP

- Did you feel you were working collaboratively with the client?
- Do you think the client felt you understood her?
- Did you feel you were in charge of the therapy or that the client was in charge?
- Do you think the client felt acknowledged as the expert on her/his own experience?
- Did you feel you followed the goals and topics that the client wanted to focus on?
- Do you think the client felt listened too?

5. THERAPEUTIC PRACTICES (EXPERIENCE OF OUTCOMES)

- What events or interventions during the therapy process did you feel were the most significant or that seemed to help change to occur?
- What events or interventions did you feel were least helpful?
- Did you discuss any of this with the client?