THE POTENTIAL THERAPEUTIC VALUE OF THERAPIST STUCKNESS IN SYSTEMIC PRACTICE

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> "I remember my childhood names for grasses and secret flowers. I remember where a toad may live and what time the birds awaken in the summer-and what trees and seasons smelled like-how people looked and walked and smelled even."
> Steinbeck [1952, 7].

Storytelling seeks to synchronize life with the process of making sense of the world. Storytelling invites the reader to visualize the story, to observe the moving script, and to reach his or her own understanding. It is a journey.

To transform this thesis from an objective theoretical and research account to a moving study that encompassing shifts in observations, that is, both personal and theoretical observations, I have approach this study with storytelling in mind. For you to understand where this idea came from, I would like to share with you a personal story. I do appreciate that this is an unusual way to commence the acknowledgement section, and more so the thesis, but I do feel that it brings you the reader, into my world, and the way I see knowledge and knowledge development.

Let us start. Storytellers surrounded my early life. My grandparents told stories. They spoke of life, communities and tradition. The stage would be set for the telling of these stories. People gathered with a sense of reverence gathered in the air. The story telling would commence with an expression of interest then follow with an ebb and flow movement between the themes to allow the listeners time to reflect and notice the changing terrain. As a child, I listened. I wondered about where the story would take us. What horizon might we reach? And, what might lie on the other side.

I ask you to read this thesis like a story. It has themes and characters, with the road taking twists and turns. The writing of this thesis and its style acknowledges my tradition. I thank my ancestors and all those who gathered for the storytelling.

To tell a story is interesting. However, a story about tradition is different from a story about theory. I would like to acknowledge at this point, my principal supervisor, Dr. Charlotte Burck. Dr. Burck at all times, kept one-step ahead of me. I followed her path. Her ideas were always insightful. She encouraged a different journey. A journey that I had not initially envisaged. A journey that challenged my way of observing systemic practice.

I would also like to acknowledge my second supervisor, Professor Andrew Cooper. At the start of my journey at the Tavistock and Portman N.H.S. Foundation Trust, Professor Cooper presented a workshop. He spoke of reflexivity in a way that made it tangible. He translated complex theoretical ideas to practice. This knowledge stayed with me throughout the writing of this thesis.

Systemic practice has many dimensions to its story. It has diverse topics. Professor Peter Rober, the systemic ideas that he explored and developed, caught my attention many years ago. The continuous flow of theoretical and practice ideas from Professor Rober instigated this thesis and provided a backdrop of knowledge for me to draw on.

I would like to acknowledge the academic team at the Tavistock and Portman Foundation. They were at all times encouraging and supportive. I feel it is important that I mention the Library at the Tavistock, the team of which demonstrated huge patience with me.

To bring this acknowledgement closer to my home, first, I would like to acknowledge the clinical team at the Mater Misercordiae University Hospital / Family Therapy Department. This team introduced me to systemic practice. Dr. Jim Sheehan introduced the dialogical approach to my training group. He encouraged a way of practice that brought to the fore the human aspect of therapy.

It is important that I acknowledge my colleagues at my work setting, always ready to listen and share their thoughts. I cannot forget the library attached to the hospital that I work in. The librarians were excellent and I am surprised how patient they were considering the ridiculous late hour requests I made.

Again, closer to home, I want to express my deep appreciation to the family therapists who took part in this journey. They shared stories of distress, sadness and hope. Without these stories, this project would not have happened.

To conclude this acknowledgement, it is important that I mention my family. If they joined this discussion, I feel they might mention the times that I forgot to cook the dinner. How could I respond to that? Nevertheless, maybe I will end this section with the knowledge that my sons walked this journey with me. Their youthful stamina became my stamina. My younger son, Keith, offered creative reflections, reflections that drew on the idea that the gathering of knowledge is a continuous horizon that at times may surprise us, at times challenge us, but always add to the person that we are. These shared thoughts became my travelling companion.

It is now time to read this thesis. I wish you a good journey.

Contents:

ABSTRACT:

Theory development and research within the sphere of family therapy is an expression of who we are, where we are, and where our next horizon may lead us. The dialogical perspective introduces a new horizon to the systemic paradigm, a shift that supports new ways of observing practice. This project explored therapist stuckness, one aspect of the impasse phenomena, through this new lens. In response, the project introduced an alternative consultation model. The task of the model is to support a therapist when they encounter a stuck phase in therapy.

Thus, the principal aim of this qualitative project was to ascertain if a consultation model influenced by the aforementioned perspective supports a therapist who is experiencing a stuck phase and if the stuck phenomenon is of value to the therapeutic process.

Action Research methodology directed this inquiry. The research followed an action/reflexive cyclical trajectory with a marked responsiveness to the participant's ideas and experiences as they engaged in the consultation and the participant/researcher dialogue. Hence, the primary method of data gathering entailed the engagement of family therapists in a consultation lead by the model. Each participant engaged in one consultation and one post consultation review. The analysis was directed through a synergy of lenses, namely: Interpretative Phenomenology Analysis, a dialogical lens and a Gadamerian Hermeneutic reflexive framework. The outcome of the analysis was translated through the Action Research lens with the outcome modifying the model format as required.

The findings revealed that therapist stuckness could be described as a multi-positioned, responsive process. This description demonstrates the complex relationship between the therapist and client group. The description points towards the need to address stuckness in a way that observes how the therapist and client group connect and participate in the therapeutic trajectory. The developed Dialogical Consultation Model attempts to address this task.

From this research, it is envisaged that the developed consultation model will provide a platform to develop a more advanced reflexive supervisory tool for use in systemic training and general systemic practice.

PREFACE AND READERS GUIDE:

> "Never, never, never believe that any war will be smooth and easy...The statesman who yields to war fever must realise that, once the signal is given, he is no longer the master of policy but the slave of unforeseeable and uncontrollable events".
> Churchill [1930, 22].

This has been a long journey. The project started many years ago, it incorporates many ideas. Some borrowed. Some new. This journey brought me through many changes in my own life, in the lives of people around me, and in the way, I observe systemic practice.

I started this project with ideas that encompassed both the cognitive and dialogical perspective. I reflected on therapist stuckness, one aspect of the impasse phenomena, and felt that a consultation model underpinned by the cognitive science ideas could support a therapist to transcend the stuck phase. As I moved through the project, my thinking altered. I had the opportunity to observe more closely how family therapists reflect during the course of a consultation process. I began to notice that a cognitive map, one that delineates or separates the various internal reflections, is unable to address all aspects of systemic reflection.

With that, my perspective moved more towards the dialogical perspective. This shift created a need to find new ways of advancing the model, new ways of observing how the therapists engaged with the model, and new ways of analysing the effectiveness of the model. I needed to be more closely attuned to the dialogical way of observation. This change of perspective brought forth complications. To translate the changes in my perspective while simultaneously writing up the research trajectory, the participant's observations and the project outcomes, necessitated clarity in accommodating the various actors in this project. There are some shortcomings.

Thus, to generate some clarity, I have divided the project into three sections with each section speaking to the reader differently. The first section speaks from my academic voice. It is static and theoretical in form. It explains the theoretical influences, how the literature supports the project and outlines the selected research design. It comprises of four chapters: Chapter 1 introduces the projects theme and task, and places it into context. Chapter 2 reviews the literature. Chapter 3 introduces the first draft of the Dialogical Consultation Model. To conclude this section, Chapter 4 outlines the research design.

Section B presents the analysis. This brings with it a different form of writing. It is more fluid with the narration shifting between the various voices i.e. the researcher's voice, the participant's voice, the literature voice and the collaborative voice. I do understand that it is difficult to read this piece of work in light of the changing voices and my changing perspective. To lend some clarity, I will outline this sections map. This section opens with Chapter 5. This chapter reviews the pilot study and puts forward a number of criticisms. It looks at the theoretical influences, the model, its task and construction, in light of my changing perspective. Chapter 6 brings together the five consultations. It weaves through the various voices with a continuous observation of the dialogical model and how it fits with the emergent reflections and themes. The modifications to the model are continuous and reflect the ongoing research dialogue [see Appendix 8]. This activity fits an Action Research lens. Chapter 7 brings together the emergent themes and presents the modified version of the Dialogical Consultation Model, as influenced by the research trajectory. This chapter concludes with a critique of the model with a subsequent introduction of a short version of the model [see Appendix 10].

Section C brings the project together. It comprises of two chapters. Chapter 8 comments on aspects of the research methodology. Chapter 9 closes the study with the inclusion of a number of shared thoughts on the project, how it influenced me as a family therapist, and, in what part the model may play in future research and in systemic practice. Thus, this section speaks from a number of voices, a theoretical voice, a research voice and my own personal voice.

I have included introductions to each section and to each chapter in order to assist the reader to keep an overview of the thesis.

This project has been a learning process for me. It brought with it frustration. Frustration with the task of disentangling theories and bringing them together in a manageable and meaningful way. This project brought satisfaction. Satisfaction, with the completion of the project, and, with new ways of seeing the old. I hope the reading of this project stimulates your interest in how you position yourself as a therapist and brings to you different reflections.

SECTION A:

INTRODUCTION, LITERATURE REVIEW, AN OVERVIEW OF THE DIALOGICAL CONSULTATION MODEL AND THE RESEARCH DESIGN.

Orientation to Chapters 1 - 4:

Section A contains four chapters. Chapter 1 introduces the research project. In chapter 2, the literature review is presented with a discussion on how we can observe therapist stuckness through the dialogical perspective and the therapeutic-use-of-self-concept. The existing approaches to therapist stuckness will be overviewed. The ideas of Rober [1999, 2005b, 2009, 2010, 2011] will lead the discussions. In chapter 3, the first draft of the Dialogical Consultation Model is presented with the preliminary aims, objectives and method for evaluating included. Chapter 4 presents the design of the project.

CHAPTER 1:

INTRODUCTION TO THE RESEARCH PROJECT:

> "This story has grown since I started it. From a novel about people, it has become a novel about the world…The new eye is being opened here in the west-the new seeing."
> Steinbeck [1935, vii].

1.1. Introduction:

The aim of this inquiry is to elaborate on the existing descriptions of therapist stuckness, introduce a dialogical framed intervention that aims to support a therapist when they encounter a stuck episode, observe its usefulness and modify accordingly.
This chapter will bring this project into context. The chapter will open with an overview of the changing perspective of systemic practice. Therapist stuckness, one aspect of the impasse phenomena will be overviewed. The dialogical model will be overviewed with some discussion points introduced. The chapter will conclude with a synopsis of what the Dialogical Model will bring to systemic therapy.

Impetus:

1.2. Systemic Therapy: An evolving paradigm:

Systemic therapy has been described as an evolving theoretical and practice paradigm [see Anderson and Gehart, 2007; Aponte and Kissil, 2012]. It is interesting to observe the shifts in systemic practice, from first order cybernetics to the current dialogical perspective, a perspective that appears to encompass a theoretical and practice position that defines an ontological and epistemological shift in relation to the original systemic frame of inquiry [see Anderson, 2007b; Anderson and Gehart, 2007; Rober, 2005b; Shotter, 2000]. The evolving nature of systemic practice calls to attention the need to continuously articulate, define and redefine systemic theory and practice. The dialogical self-theories bring the systemic paradigm to a new wave of inquiry. It offers a new theoretical lens from which to look at

practice phenomena and elaborate on their definition and their position within therapy. The dialogical frame of inquiry offers a new way to look at the impasse phenomena.

1.3. A move towards a wider definition of therapist stuckness:

To date, the emergence of an impasse in therapy has attracted numerous discussions [Beaudoin, 2008; Couture, 2006; Flaskas, 2009, 2010; Rober, 1999]. Each author examines different aspects of an impasse [see Flaskas, 2009, 2010]. These discussions draw attention towards the multifaceted composition of this phenomenon. I believe each discussion and aligned practice suggestion compliments the other discussions and strengthens the understanding and approach to an impasse in therapy.

This project is interested in therapist stuckness. The project will draw on the ideas of Rober [1999, 2005a, 2005b, 2008a, 2008b, 2008c, 2010, 2011] and aligned practice suggestions. The project will put forward a dialogical consultation model that in practice may add to the existing approaches.

Thus, what is the project striving to achieve? The project will examine how a therapist stuck phase responds to a consultation that is influenced by the dialogical perspective. To position the inquiry through a dialogical perspective has the potential to prompt a different exploration, an exploration that will focus on the therapist's internal dialogue and how a stuck phase is observed through that lens.

1.4. How will the research be conducted?

The research project will be directed through an Action Research lens. Interpretative Phenomenological Analysis [I.P.A.] will guide the analysis process. In addition, I, the researcher, bring to this project a number of prejudices. To acknowledge and address these biases, a Gadamerian[1] reflexive framework was developed. The framework will underpin the analysis reflections [2][see Gadamer, 1976, 1990/1960].

This mixed method approach brings to this project a research process that is investigative [Action Research], that provides a mode of inquiry that shows interest in observing the

[1] To succinctly describe and to translate to research, Gadamerian hermeneutics can be described as a reflexive process that observes the researcher's and the research participant's ideas, prejudices and expectations in a research mode that aspires to generate a dialogue that explores the potentiality of all dialogues [Gadamerian, 1976, 1990/1960].

2Gadamer [1976, 1990/1960] introduced the idea of horizons, a concept that places emphasis on how to enrich dialogue and suggests that knowledge is not static but rather a process that arises out of the interaction and opening up of difference. This concept will underpin the reflexive framework.

experiences of the participants [Interpretative Phenomenological Analysis], is critically reflexive [as influenced by Gadamerian hermeneutics], and has the ability to evaluate the effectiveness of the model in practice in a tangible manner.

The project's design has been introduced. The principal aim of the research is to introduce an alternative form of consultation. The following discussion will introduce the Dialogical Consultation Model:

1.5. The Dialogical Consultation Model:

The dialogical consultation model will direct attention to the inner dialogue of the therapist. It reflects the ideas of Rober [1999, 2005a, 2005b, 2008a, 2008c, 2010, 2011]. The first question that arises is, why develop a dialogical model. The following discussion will address this question. The opening discussion will be followed by a synopsis of the theoretical ideas that influence the model. A discussion on how the model will be evaluated will follow. The closing notes will observe its position in contemporary systemic practice.

1.6. Why develop a dialogical consultation model?

> "Without context, words and actions have no meaning at all"
> Bateson [1979, 24].

There is a growing awareness of the central position that the therapist, and, as part of that discussion, the experiencing-self of the therapist holds in therapeutic practice [see Elkaim, 1997; Flaskas, 2005b, 2009; Jenson, 2007; Jones, 1996, 1998, 2003; Rober, 1999, 2010, 2011; Schon, 1983]. Schon [1983] argues that the personal epistemology of the therapist is embodied in their "cognitive map" and that this map shapes what they notice in the therapeutic encounter, their subsequent thoughts, reflections and aligned responses [1983, 73]. However, Jensen [2007] argues that the personal and private life experiences of the therapist are often overlooked in contemporary systemic practice.

It can be argued that by supporting an observation and exploration of the therapist's internal dialogue will prompt the therapist to be more present, engaged and open to their inner-self and thus create space for new or alternative reflections that connect with the therapeutic encounter [see Rober, 1999, 2010, 2011].

Rober [1999, 2010, 2011] put forward a number of reflexive practice models. Each suggestion concentrates on an exploration and articulation of the therapist's experiencing-

self. The aim of these reflexive ideas is to support the therapist to develop a heightened awareness towards their experiencing-self and from that reflexive position generate new or alternate ways of observing and thus engaging.

Rober's [1999, 2010, 2011] discussions advocate a move towards the therapist's observing-of-self, and subsequently, a more enhanced use-of-self in the therapeutic environment. This illustrates a shift in family therapy from the traditional interest in the mechanistic processes of the family to an interest in the self of the therapist and their position in therapy [see Elkaim, 1997; Flaskas, 2010; Jenson, 2007; Rober, 1999, 2008a, 2009, 2010, 2011]. This growing interest in the therapist-use-of-self prompted the development of the Dialogical Consultation model. The model is an extension of the described ideas with particular reference towards Rober's [1999, 2005b, 2009, 2010, 2011] discussions.

1.7. The consultation process: Towards a reflexive practice:

Therapist self-reflexivity can be described as a process where the therapist observes how they listen, connect and respond to the client group [see Burnham, 2005; Rober, 1999, 2010, 2011]. The emphasis is on the internal dialogue of the therapist [see Rober, 1999]. This activity is interested in the resources available through the exploration of the therapist's internal dialogue with the aim to enhance the therapeutic connection [see Burnham, 2005].

How does this activity fit into the consultation process? The consultation process, as an activity, has evolved in response to the changing ethos of systemic practice [see Daniel 2013; Mason, 2013; Ungar, 2006]. Its interest lies in the connection between the consultant and the consultee, and, how that connection may support the consultee to explore the links between their self-narratives, the evolving therapeutic story, and, the theoretical influences that may guide that process [see Daniel, 2013]. Thus, the contribution of the consultant is central [see Mason, 2013]. This process creates and invites dialogue [see Rober, 2010]. Dialogue creates new ways of observing the known.

The dialogical model provides a framework for the consultant. The framework is a guide. It supports the exploration of all aspects of the therapist's self-dialogue. The consultant, fitting with current descriptions of the consultation process, can generate a responsive dialogue in response to the therapist's self-exploratory dialogue.

1.8. What will the model entail?

The first draft of the model will comprise of a compilation of structured questions that supports the therapist to study their internal dialogue. For the opening draft, the questions will draw from both the cognitive and dialogical perspective. In action, the model will support the therapist too observe the historical and emergent positions, the presence of voice dominance or submission and the presence of flexibility or inflexibility. The task of this process is to generate an appreciation of all reflections with a move towards a more flexible internal dialogue that is open to alternate ways of observing and connecting with the client group [see Appendix 8: Pilot draft one].

1.9. Will the Dialogical Consultation Model fit with contemporary systemic thinking?

How will a structured format fit with the dialogical approach, an approach that speaks of fluidity and creativity?

The dialogical perspective brings with it a therapeutic activity that is living in the moment. It is an interactive process in which all parties contribute, and what is created is unique within "an always becoming, never ending process" [Flaskas, 2007a, 4]. The dialogical perspective, although it allows for an authentic, reciprocal activity, a mutual inquiry where the responses of the other creates the context for the emerging dialogue, this process cannot promote a freefall dimension to the therapeutic process. The model questions, although structured in format, aim to prompt the therapist to connect with their dialogic-self[3] as they participate in the shared dialogue of family therapy. It can be described as a preparatory process. In practice, it creates a space for the therapist to think about how they observe and translate their ideas and experiences into the therapeutic encounter [see Rober, 1999, 2005a, 2005b, 2010, 2011]. Thus, it has the potential to prevent a freefall dialogue, a dilemma that can arise in the complex environment of family therapy.

2.1. What are the theoretical influences?

As the project progressed, the theoretical influences changed. These changes reflect how the participants engaged with the model.

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[3] Through the course of this project, I will refer to the idea of *a dialogic –self* [selected highlight]. To define this term, I will position it within a dialogical perspective and thus a post-modern lens. Hence, the dialogic-self refers to the complex multi-positioned connected collection of historical, here-and-now, experiencing and emergent reciprocal empathic observations and reflections [i.e. the social–self] that each person brings to the therapeutic encounter [see Hermans, 1999, 2006; Rober, 1999, 2005b].

A brief description of the theoretical influences will follow:

The primary theories:

I. The dialogical theories:

The concept of dialogue, the dialogical-self theories, and how they influence current systemic practice, underpin the Consultation Model. To explore and further understand therapist stuckness, the project will draw on the ideas Hermans [1999, 2001a, 2001b, 2003, 2006, 2008a, 2008b] Hermans and Dimaggio [2004], Molina and del Rio [2008], Raggatt [2004] and Bertau and Gonclaves [2007].

II. The therapist therapeutic-use-of-self-concept:

This concept as a whole defies precise definition or interpretation. Its description continues to evolve in response to shifts in ontological and epistemological thinking. In addition, no clear narrative links this concept between the various psychotherapeutic schools of thought. The systemic description has moved towards a description that reflects a dialogical lens, in that, the therapeutic-use-of-self entails a continuous back and forth movement between what the client group shares in the therapeutic process, how the therapist observes the stories shared, how the therapists reflects on these stories with a subsequent sharing of the therapists observation and reflections with the aim to open space for the not yet said [see Rober, 1999, 2005a, 2005b, 2010]. This description, will underpin the description of therapist stuckness and how to process it in consultation.

The opening theoretical influences:

I. The cognitive field of study:

At the start of the project, ideas from a number of theorists from the cognitive science and adjoining schools of research influenced my way of understanding the internal dialogue, how to support a therapist when they experience a stuck episode, and thus, the construction of the model [see Cunha, 2007; Ibanez, 2007a, 2007b; Ibanez and Cosmelli, 2008; Leiman, 2004; Raggatt, 2000; Valsiner, 2002]. However, as will be further discussed, the cognitive lens became less evident, in firstly, my perspective, and subsequently in the model amendments as the project progressed.

Emergent theoretical influences:

I. Gadamer [1976, 1990/1960]:

Gadamer's [1990/1960] reading of hermeneutics emerged as a key influence to the way I observed the model in action and its subsequent modifications. The concept of horizons leads this change in perspective. This concept influenced how the questions were formed.

II. Rober [1999] and Rober, Elliott, Buysse, Loots, and De Corte [2008a, 2008b]:

Rober's [1999, 2005a, 2005b, 2010, 2011] continuum of theoretical and practice ideas stimulated this study. The original model questions, their structure and style were informed by the ideas of Rober [1999].

As noted, the cognitive lens directed aspects of the model construction at the start of the project. However, as the project progressed it became evident that a cognitive lens did not address all aspects of how we can understand reflexivity as an activity in action. Rober et al [2008a, 2008b] conducted a research project that observed how therapists reflect in action. The outcome of this study described the reflexive pathway that family therapists move through during the course of a therapeutic encounter [Rober et al, 2008a, 2008b]. The reported reflexive pathway supported new ways of observing how the participants in this current project responded to the model. Thus, it shed light on how best to amend and advance the model.

The chapter so far has looked at the model and the theoretical influences. The question that arises at this stage is why study the inner dialogue? Moreover, what will this form of study add to practice? These questions will frame the following discussion.

2.2. Why study the inner dialogue?

Firstly, the model in practice will bring to the fore the inner dialogue of the therapist. It will support the therapist to observe their systemic, professional and experiencing reflections, their characteristics and position within the inner dialogue. From this activity, the participant/therapist can then self-observe. Through the process of self-observation, features of the dialogic-self i.e. the historical-self and the experiencing-self, and, linked developed self-styled reflexive patterns may emerge. It is through this self-observation process that the therapist can become more aware and appreciate aspects of their self that has the potential to influence or define the therapeutic activity.

Secondly, and an observation that arose as the project progressed, a dialogical observation of the therapist's inner dialogue has the potential to bring forth the internalised-other, a reflexive activity that illuminates the client group, the stories they shared, and, how they are observed by the therapist. This reflexive activity strengthens the presence of the client's voice and leads towards a therapeutic dialogue that is both collaborative and meaningful.

2.3. How might we observe the internal dialogue?

The question is how to observe the internal dialogical-self. I have brought together theoretical and observational ideas from a number of theorists. This observational lens helps me to observe and understand how the therapists' engage with and respond to the model.

Theorists that I have drawn from:

I. Hermans [2001b, 2008b]:

Hermans [2001b, 2008b], a leading theorist from the dialogical field explored the internal dialogical self [see page 23] and constructed the Personal Position Repertoire [PPR] method, an idiographic procedure for assessing the internal and external domains of the internal-self in terms of an organised position repertoire. The ideas developed supported both the development of the general model framework and how to observe the therapists reflexive activity in response to the model.

II. Cunha [2007]:

In addition, I drew from the dialogical ideas of Cunha [2007] who brought into her internal-self assessment observational discussions the idea of a "Position Statement" [2007, 291]. The position statement, one aspect of Cunha's [2007] discussion that I borrowed and placed in the model format, supports the therapist to move towards and strengthen their meta-observational position, and, for the research perspective, provides a measurement tool. This concept became a key component of the model construction, how to address its aims, how to observe the internal dialogue, and, how to observe the effectiveness of the model in action.

III. Stiles et al [1990] and the theoretical advances of the assimilation model:

Stiles, W.B., Elliot, R., Llewellyn, S.P., Firth-Cozens, J.A., Margison, F.R., Shapiro, D.A. and Hardy, G. [1990], and, Stiles, Osatuke, Click, and MacKay [2004] studies focused on the

internal experiences of the client with an observation of how a person moves towards the development of more complex dialogical patterns. Stiles et al [1990] and Stiles et al [2004] introduced the concepts of meaning bridges i.e. the connecting of dialogical channels, and empathic reflections. These ideas were borrowed to observe reflexive changes.

IV. Rober et al [2008a, 2008b]:

As noted, Rober et al [2008a, 2008b] description of the internal reflexive dialogue, its composition and activity, as relevant in systemic practice, provided a way to observe the model in action.

3.1. Closing argument to the introductory chapter:

This project has two tasks. First, it will observe therapist stuckness. Secound, it will introduce a Dialogical Consultation Model. My objective is to create a consultation format that provides an alternative way to explore the dialogue of the therapist as they encounter a stuck episode. This format takes into account the changing perspective of the self [see Hermans, 2001b, 2003, 2006; Seikkula et al, 2012], and the changing perspective of systemic therapy [see Anderson, 2007b]. There are limitations to the model that I have developed, of which will be addressed at the close of the project. However, I argue that each reflexive tool that is developed adds to knowledge and provides a platform from which to advance clinical practice.

This chapter forms the introduction to the research project. It has introduced the task of the project and how it will be achieved. The following chapter will present the literature review with a discussion on how therapist stuckness is understood and processed in systemic therapy.

CHAPTER 2:

LITERATURE REVIEW:

> "It is the person of the therapist in his or her encounter with the client family who produces change in therapy".
> Minuchin [2006, 71**].**

1.1. Introduction:

The purpose of this chapter is to explore how therapist stuckness is described in literature. To place that conversation in to context the chapter will look at the changing landscape of systemic theory and practice and observe how the description of stuckness reflected these changes. The discussion will proceed with an observation of how therapist stuckness is addressed in current practice. The chapter will conclude with a provisional evaluation of how to move the impasse discussion forward.

1.2. The projects background:

The project will introduce a consultation model that aims to assist a therapist when they are experiencing a stuck phase.
In practice, the model will prompt the therapist to externalise their inner conversation [see Rober, 2010]. The externalising process will assist the therapist to observe their internal dialogue and to study how they observe and connect with the client group; and, from that observation, generate awareness into how their observational lens, and subsequent, response-building process, influences and supports the evolving therapeutic dialogue. It is anticipated that this reflexive process will, by the process of illuminating the internal dialogue of the therapist, stimulate a revising of their positioning in the therapeutic dialogue and cultivate multiple of ways of reflecting on and progressing in the therapeutic trajectory. This reflexive process can be understood as a move towards the integration of the evolving therapeutic-use-of-self ideas and the dialogical approach to therapy.

To position the inquiry through this perspective will prompt a similar exploration of impasse to Rober's [1999, 2008a, 2010, 2011] theoretical and practice ideas. What will this project then add to the systemic practice? I endeavour to develop a consultation model that advances

the joining of the dialogical theories and the contemporary therapeutic-use-of-self ideas, an activity that brings forward the ideas of Gadamer [1990/1960]. This synergy of ideas advances the intersubjective space, a process that promotes an inclusive and meaningful therapeutic trajectory.

To date this aspect of the impasse phenomena and the dialogical approach to consultation has not received research attention within the systemic field [see Seikkula, Laitila and Rober, 2012[4]]. I anticipate that this study will constructively broaden the theoretical approach to a therapist stuck phase and advance its description towards the contemporary dialogical frame of inquiry.

1.3. Literature review outline:

This project is interested in therapist stuckness. To place this theme into context, the impasse phenomena, as understood in systemic practice, will open the literature review. The impasse starting points will be outlined with attention directed towards therapist stuckness. To understand therapist stuckness the dialogical-self concepts and the therapeutic-use-of-self process will be described with a discussion on how that understanding can assist in describing therapist stuckness. The review will close with a reflection on the application of reflexive consultation models in contemporary systemic practice.

The Literature Review:

2.1. The impasse phenomena:

Therapeutic impasse is a complex phenomenon that is a common feature of therapeutic practice [Flaskas, 2005, 2009, 2010; Rober, 1999]. Impasse has attracted various explanations within the systemic field of inquiry [Beaudoin, 2008; Couture, 2006; Flaskas, 2005, 2009, 2010; Rober, 1999]. Flaskas [2005] suggests the idea of "becoming stuck" within the therapeutic process as a broad description of impasse [2005, 213].

It has been suggested that the occurrence of an impasse in the systemic environment has a number of interconnecting starting points [Flaskas, 2005, 2010]. Starting points can be

[4]Seikkula, Laitila and Rober [2012] explored the dialogical activity that occurs during the course of a family meeting. To my understanding this paper furthers dialogical investigations and its place in contemporary systemic theory.

defined as aspects in therapy that can emerge at any stage of the therapeutic process, which if not addressed, can influence the onset of an impasse. The starting points have been put forward as an underdeveloped therapeutic alliance [Flaskas, 2005, 2010]; a family's struggle with change [Hubble, Duncan and Miller, 1999]; technical stuckness [Beaudoin, 2008], conversational behaviors [Couture, 2006]; and a challenge to the therapist's capacity to remain curious or therapist stuckness [Beaudoin, 2008; Rober, 1999, 2005a].

A number of authors within the systemic field have studied the impasse phenomena with attention directed towards one of the starting points of an impasse. Beaudoin [2008] examines technical skills and draws her discussions from a narrative frame [Beaudoin, 2008]. In a research-based paper, Couture [2006] studied the conversational behaviors in family therapy [2006]. The study offers a broad understanding of how a therapist can move forward when experiencing an impasse and again draws on the narrative ideas [Couture, 2006]. Flaskas [2009, 2010] moves the discussion of impasse from the practice and technical aspects to one of a meta-perspective view of impasse. Flaskas [2009] introduces the idea of therapeutic connectedness and its role in the formation of anti-therapeutic sequences [Flaskas, 2009, 2010]. This paper expresses a move towards the contemporary understanding of co-constructive therapy, synonymous with the dialogical approach.

Rober [1999][5] draws on a synthesis of theoretical ideas to explore impasse. The dialogical-self theories, the therapeutic-use-of-self concepts and some of the more recent hermeneutic ideas [see Gadamer, 1990/1960] are brought together to describe impasse and how to process through an impasse encounter. Rober [1999] focuses on therapist stuckness. This paper illustrates how an impasse can be observed through the experiences of the therapist, and how by attending to the experiences, can provide the therapist with beneficial insight into the family system and thereby be of value to the therapeutic process. The therapist use-of-self as a therapeutic resource is an interesting idea that is not new to systemic literature[6] [see for example Elkaim, 1997; Flaskas, 2009; Larner, 1998, 2000; Pocock, 1997, 2005, 2009, 2010; Rober, 1999, 2008a, 2010]. However, what is interesting, is that Rober [1999] brings together the therapeutic-use-of-self with the dialogical view of therapy and explores how that relationship can be beneficial to the management of an impasse [1999]. It is through that

[5] Rober [1999, 2008a, 2009, 2010] extends the ideas introduced in the paper published in 1999 with further emphasis on the experiencing of the therapist and how through a constructive reflexive exercise can promote a "multiplicity of ideas rather than a universal truth" [2010, 167].

[6] In general, early systemic ideas were influenced heavily by the split between cognitions and emotions. Observation of the therapist's experiencing-self was understood, at that time, as a regressive step into psychoanalytic thinking [see Pocock, 2010].

discussion that Rober [1999] portrays how an impasse can be of value to the therapeutic encounter [1999].

The following discussion will open with an overview of the dialogical perspective. A discussion of the therapeutic-use–of-self-concept will follow. Rober's [1999] description of therapist stuckness as understood through the two themes will conclude the discussion:

3.1. The Dialogical Perspective:

> "A particular type of talk in which participants engage with each other [out loud] and with themselves [silently] in a mutually shared inquiry".
> Anderson [2007b].

To broadly describe, the dialogical perspective moves the systemic frame of inquiry to a therapeutic encounter that articulates an expression of the interrelated concepts of participant unity [Gadamer, 1976, 1990/1960], and, polyphonic collectivity [Bakhtin, 1981, 1984, 1986]. To define the aforementioned concepts, in relation to therapeutic activity, the concept of participant unity refers to a therapeutic relationship that strives to generate and uphold a co-constructive frame of interaction [Anderson, 2007a, 2007b, Rober, 1999, 2005b]. And, if my reading is accurate, as the dialogical-self theories, and in correlation, the dialogical approach and systemic interpretation, continues to evolve and elaborate, polyphonic collectivity refers to the realisation and acknowledgement of all dialogues, the internal and external voices of both therapist and client group and the evolving collaborative voice [Anderson, 2007b, Rober, 2005b; Seikkula, Laitila and Rober, 2012].

To place both concepts into practice, the dialogical search for meaning within the systemic environment has been described as the gathering together of the multiple voices, the external voices of the client and therapist; and, the internal voices, to include the historical and the here-and-now experiencing-voices, with the aim to create an inclusive therapeutic encounter which endeavours to promote an interactive, generative trajectory, a responsive reflexive process that is living in the moment [Anderson and Gehart, 2007; Bakhtin, 1981, 1984, 1986; Gadamer, 1976, 1990/1960; Rober, 1999, 2005b, 2008c; Seikkula et al, 2012; Shotter, 2000].

The dialogical perspective, in terms of how it is discussed in systemic literature, explores the two aforementioned themes [Anderson and Gehart, 2007; Rober, 1999, 2005b, 2009, 2010;

Seikkula et al 2012; Shotter, 2000]. For this project, my interest lies with the internal dialogue concept. To move towards a definition of the internal dialogue concept, the description will start with Hermans [1999, 2001a, 2001b, 2003, 2008a] and Hermans and Dimaggio's [2004] landscape of the mind theoretical discussions, as inspired by James [1890/2010] and Bakhtin [1981, 1984, 1986]. Hermans and Dimaggio [2004] conceptualise the internal-self as a "multiplicity of voices" that have the potential to enter into a dialogical relationship, to entertain, examine, or interrogate each other, and subsequently arrive at a proposal or decision [Hermans and Dimaggio, 2004, 13]. Hermans [2001a, 2008] proposes that the voices arise from diverse and sometimes competing influences e.g. cultural, social, moral, experiential, and professional. According to Hermans [1999, 2003], the act of participating in a dialogue entails the participant listening, and by doing so, activating the internal dialogue, a dialogical activity that has a number of built-in mechanisms that can prompt either a multiplicity or inflexibility of thought with a move towards a response building activity [Hermans, 1999, 2003; Hermans and Dimaggio, 2004].

This theme, as explored in systemic practice, I understand, first emerged in the writings of Tom Andersen[7] [1995]. Andersen [1995] directed attention towards the therapist's self-talk [see Andersen, 1995, 18]. Andersen [1995] looked at the idea of observing this inner talk and how its observation could support the therapeutic encounter. This theme re-emerges in Rober's [1999, 2002, 2005b, 2010] and Rober et al [2008a, 2008b] theoretical, research and practice discussions. Rober [1999, 2002, 2005b, 2010] and Rober et al [2008a, 2008b] put forward the suggestion that by incorporating the dialogical ideas of the self into theoretical and linked practice ideas, can, in practice, support the therapist to pay closer attention to their internal professional and systemic ideas, and the internalised-other voice and how they connect with their experiencing reflections as they participate in therapy. I believe, this process can aid the construction of a more inclusive meta-reflexive position, a reflexive activity that has the potential to increase a heightened attention towards how the therapist positions themselves in therapy, and from that process generate a more curious position towards how they observe and connect with the client group [see Rober, 1999, 2005b, 2010].

4.1. The therapeutic-use-of-self: A theoretical and practice overview:

[7] Anderson [1995] refers to the ideas of Vygotsky [1988] who studied the relationship between the inner and outer dialogues.

In general, early systemic theorists considered that the therapeutic-use-of-the-therapist was not relevant in practice[8] [see Pocock, 2010]. However, the significance of the therapist has been highlighted in a number of more recent papers [Flaskas, 2009, 2010; Jenson, 2007; Larner 1998; Pocock, 2010; Rober, 1999, 2010]. What brought this change? Family therapy experienced a paradigm shift in the late 1970s with a move from a first order to a second order perspective that made visible the therapist as an active and experiencing participant in the therapeutic process [see Hoffman, 1985]. In practice, this lens transferred attention from solely observing the family interactions and communication patterns to observing simultaneously how the self-of-the-therapist and the client group, observe, experience and participate in the therapeutic encounter and emerging dialogue [Flaskas, 2009; Jones, 1996, 1998, 2003; Pocock, 2010; Rober, 1999, 2010, 2011; Von Foerster, 1990].

How was the therapist-use-of-self-concept initially explored in systemic practice? With the shift in the systemic perspective and the linked growing interest in the therapist as an active participant in the therapeutic process several authors brought forward the idea of observing the positioning of the therapist in practice. Byrne and McCarthy[9] [1988, 1998] explored how a therapist positions themselves in relation to the family system, and the family script, and wondered how that positioning may have the potential to overshadow some aspects of the client group composition or client stories. Therefore, the therapeutic-use-of-self process at that time, according to Byrne and McCarthy [1988, 1998], was interested in identifying what position the therapist connected to, with a move towards disconnecting from that position and relocating to an alternative position. The aim of this repositioning process, according to these authors was to connect with marginalised positions.

From a similar viewpoint, Cecchin, Lane and Ray [1992, 1994] explored how aspects of the client group or client narrative had the potential to trigger underlying therapist prejudices, with the process of therapeutic-use-of-self placing weight on uncovering or being conscious of the sway of the prejudice in therapy. A paper by Jones [2003] reflects Cecchin et al [1992, 1994] ideas. This author described the therapeutic-use-of-self as a "bouncing around" [Jones, 2003, 240] of ideas with a close observation of what the therapist brings to the therapeutic

[8] In contrast, Bowens [1967, 1978] introduced a paper that explored the family of origin of the therapist and how that influences the therapeutic process [see Young, 2003]. Bowen's transgenerational perspective influenced further studies with a model developed in 1980 [see Lieberman, 1980].

[9]The Fifth Province Approach to Systemic Therapy was developed in Dublin from the early 1980s by Dr. Nollaig Byrne, Imelda McCarthy and Philip Kearney.

encounter, how they contribute to the construction of meaning, and, how that construction may have the potential to marginalise or silence some scripts.

In parallel to the earlier discussions on prejudices, several authors at that time examined the family-of-origin of the therapist. They suggested that this particular exploratory process could increase the therapist's awareness of the influence of generational themes and by doing so move the therapist towards a more balanced approach to complex family dynamics and narratives [Benningfield, 1987; Bowen, 1978; Lieberman, 1980; Timm and Blow 1999]. This theme was further developed with Jensen [2007] exploring through a grounded theory research project how the family of origin, and linked to the therapist's political and cultural background, the social and economic setting and religious commitments, can frame how a therapist constructs a meaning.

4.2. How can we understand the therapeutic-use-of-self concept through the contemporary perspective?

The dialogical perspective altered the observational lens and in response altered the therapeutic-use-of-self descriptions. Mason's [2010] discussion in relation to the therapeutic-use-of-self moves towards exploring the therapist's inner conversation. Although there is no direct reference to the internal dialogue, the discussion points towards the internal experiences of the therapist. Mason [2010] proposes that the therapeutic-use-of-self is enhanced by the therapist being curious and asking questions about what ideas they bring to the client meeting. Similarly, Haber and Hawley [2004] report, that the therapeutic-use-of-self, as a process, entails the therapist examining their internal experiences in response to the therapeutic system. These authors suggest that through the process of deconstructing the internal experiences the therapist can increase their awareness of their-self, and subsequently have the potential to bring new aspects of their-self into the therapeutic meeting. Haber and Haley [2004] propose that this activity can enhance the therapeutic dialogue.

In continuation, Rober [1999] describes the therapeutic-use-of-self as a reflexive process that involves a back and forth type of reflexive movement. According to Rober [1999], this reflexive activity entails an observation of the self, to include the experiencing-self[10], the

[10] That is, both the historical and the here-and-now experiencing-self [see Rober, 1999].

professional and theoretical–self[11], which emerges in response to the therapeutic encounter. The aim of this form of self-observation, according to Rober's [1999] discussion, if my reading is accurate, is too illuminate the interface between what the therapist brings to the therapeutic encounter, how they listen to the shared family stories, what images or ideas emerge in response with the potential to generate new or alternative reflections that may constructively stimulate the therapeutic dialogue [Rober, 1999, 2005b, 2010].

Rober [1999] draws on the hermeneutic circle concept to advance the therapeutic-use-of-self description[12]. The introduction of this concept brings to the therapeutic-use-of-self discussions a reflexive process that simultaneously observes the emergent ideas of the therapist in response to the therapeutic encounter, how they are delivered into the shared space and a reflection on how it is received by the client group [Rober, 1999, 2005b]. This reading promotes the idea of a reciprocal dimension to the reflexive process.

To bring these ideas together, a number of authors put forward reflexive ideas that support the therapist to generate a more open creative position towards the family's script [Byrne and McCarthy, 1988, 1998; Rober, 1999, 2005a, 2005b; Von Forester, 1990]. A small number of writers developed reflexive ideas that, in practice, prompt the therapist to increase their awareness of aspects of their self that may hinder the therapeutic process [Aponte and Kissel, 2012; Burnham, 1992; Cecchin et al, 1992, 1994; Jones, 1996, 1998, 2003].

Some of the more recent descriptions draw on the dialogical concepts of the inner dialogue [Haber and Hawley, 2004; Rober, 1999, 2010, 2011]. Rober [1999, 2010, 2011] suggests a move towards an observation of the internal dialogue with the aim to support the therapist to be more present with themselves and from that position be more present during the encounter with the other [Rober, 1999, 2010, 2011].

[11] For this project, the term, theoretical–self will be replaced by the term, systemic-self. It has been observed through the course of conducting the consultations for this project, that, the research participants [family therapists] relate more positively to the term systemic-self.

[12]Rober [2005a, 2005b, 2008a, 2008b, 2010, 2011] post Rober [1999] paper extends his theoretical discussions with a prominent inclusion of the social-self or the dialogical-self within the therapeutic system. This perspective draws on relational hermeneutics, dialogue and the dialogical-self descriptions with an emphasis on responsiveness and the dialogic nature of therapy [see Rober, 2005b, 2010, 2011].

Table 1: The therapeutic-use-of-therapist reflexive activity framework:

How can we define therapeutic-use-of-self as influenced by the dialogical perspective?
From the literature review, the therapeutic-use-of-self process can be understood as encompassing a number of interrelated reflexive steps: 1st phase: The therapeutic understanding-of-self with emphasis towards the family and culture of origin. 2nd phase: The therapeutic observation-of-self, the historical-self and the emergent-self i.e. the systemic, professional and experiencing-self on reflection of the therapeutic encounter with attention towards what ideas, questions and images emerge in response to the therapeutic encounter. 3rd phase: An introduction of some of the emergent ideas into the shared space with a reflection on how they are received by the client group and how they influence the therapeutic dialogue, with a back and forth movement between all phases.

How can we understand therapist stuckness through a lens that brings together the internal dialogue [as a component of the dialogical descriptions] and therapeutic-use-of-self ideas?
Rober's [1999] discussion on therapist stuckness draws on the contemporary perspectives of the self, as developed in the dialogical-self theoretical discussions [Hermans and Dimaggio, 2004; Rober, 2005b]. With reference towards the dialogical theories, Rober [1999] suggests that therapist stuckness can emerge when the existence of certain aspects of the self or certain internal voices are dismissed or, when the internal negotiation process is dominated by one position or by taking a position of certainty rather than curiosity. From that description, the therapeutic-use-of-self trajectory would entail an observation of the internal dialogue with a move towards the bringing forth of all positions, or in systemic terms, all ideas, reflections and hunches, with the potential to develop a growing awareness of their influence on the internal dialogue and the emerging external dialogue or their potential influence if shared into the therapeutic dialogue [Rober, 1999, 2010].
Rober [1999, 2010, 2011] put forward a number of reflexive ideas that incorporate the dialogical and therapeutic-use-of-self ideas. The initial reflexive model placed emphasis on

the therapist's experiencing-self as shaped by the therapeutic encounter [Rober, 1999]. In this reflexive activity the therapist is encouraged to introduce aspects of their emerging-self into the therapeutic encounter with the aim to prompt the client group to share the "not yet-said" [1999, 220]. The second model highlights the complexity of the therapist's internal dialogue and looks at how aspects of the therapist-self are not always shared in the session. This model incorporates the use of metaphorical images [see Rober, 2010][13]. In practice, the model requests a supervisory group to step back from the therapeutic encounter[14], reflect on the family composition and the stories shared and from that reflexive position, envisage an image that reflects their understanding of the encounter. According to Rober [2010], the use of metaphorical images within a reflexive trajectory creates a reflexive space where the therapist can experiment with new ways of connecting and exploring with a client's story and thereby be more open to new dialogical positions. The third set of reflexive ideas, again concentrates on the therapist's experiencing-self [Rober, 2011]. With interest, this paper looks at the experiencing-self concept from a different position. This paper explores how the emergent experiencing-self may invite the therapist into the unhelpful relational patterns of the family system and thus continue the destructive family scenarios that brought the client group to therapy [Rober, 2011].

Rober [1999, 2010, 2011] brings to systemic practice an alternative practice lens. This project will introduce a consultation model that draws on the dialogical description of the self and the contemporary therapeutic-use-of-self ideas [see Rober, 1999, 2010, 2011]. The aim of the model is to support a therapist when they experience stuckness in therapy. Similar to Rober [1999, 2010, 2011], it will draw attention to the therapist as an individual experiencing the therapeutic encounter, how they connect with the family and the stories they share [Bertrando, 2007; Flaskas, 2010; Pocock, 2010; Rober, 1999, 2008a, 2008b, 2010, 2011; Rober et al, 2008a, 2008b].

5.1. Closing observations:

[13] The use of metaphorical images as a tool to explore the systemic process, as noted by Rober [2010], was inspired by work of the family therapist, Edith Tilmans-Ostyn [see Rober, 2010, 161].

[14] Each reflexive concept and model encourages the therapist to take a step back from the therapeutic process. In practice, they generate a meta-reflexive position from where the therapist can reflect on their observations and how they connect with the client group in a less emotive environment. I believe this activity generates a safe place for the therapist to explore their emergent experiences and thus allow them to re-engage with the family in a way that is supportive [see Rober, 2011].

Mason [2010] reported that as a visiting supervisor to family clinics he noticed that although clinical teams report that they approach family therapy from a second order perspective, they overlook this perspective at the pre and post client group session team discussions with their reflections solely focused on the family's stories and how they participate in therapy. Similarly, Rober et al [2008a], during the course of conducting a qualitative research project on therapists cognitive activity in response to a family session reported that the participating therapists did not feel that it was necessary to share their "personal reflections" [see Rober et al, 2008a, 55]. Correspondingly, Jensen [2007] argues that interest in the therapist as a person with a history has decreased in the last twenty years.

The literature review brought into focus the dialogical perspective and the therapeutic-use-of-self concept. The discussion illustrated how both ideas can support movement in therapy. Rober [1999, 2010, 2011] put forward reflexive ideas and models[15] underpinned by these concepts. This project will draw from Rober's [1999, 2010, 2011] ideas and introduce a dialogical consultation model that highlights the complex internal dialogue of the therapist and how through its externalisation can support a therapist to transcend a stuck phase. The introduction of this model responds to Rober et al [2008a], Mason [2010] and Jensen's [2007] noted concerns.

The following chapter will introduce the first draft of the Dialogical Consultation Model[16] and its implications to practice. The project is interested in how family therapists respond to an alternative consultation model. The project will evaluate if it is useful for the therapist when they feel stuck. In light of the task of the project, Action Research will direct this investigation. The research design will be discussed in chapter four.

[15] For this project, I am defining Rober's [1999, 2010] reflexive activities as reflexive models. This is not an accurate interpretation as Rober [2010] described the second reflexive model as a training exercise that in practice aims to "train the clinical skills of respectful inquiry and constructive hypothesizing" [2010, 158]. I use the term model as a general descriptive term.

[16] The initial draft was for use in the pilot study.

CHAPTER 3:

THE DIALOGICAL CONSULTATION MODEL:

> "An existing individual is always in the process of becoming..."
> Sartre [1947, xvii].

1.1. Introduction:

This chapter will introduce the first draft of the Dialogical Consultation Model. As the research proceeds, the format and aligned evaluation framework that is described at this stage will undergo multiple evaluations and modifications in response to the action/reflexive/evaluation cycle characteristic of Action Research. The developmental trajectory of the model will be described in Chapter 5.

1.2. Introduction to the Dialogical Consultation Model:

The dialogical perspective has attracted increasing academic and practice attention in the Systemic field of inquiry [Andersen, 1995; Anderson and Gehart, 2007; Arnkil and Seikkula, 2006; Bertrando, 2007; Rober, 1999, 2005a, 2005b, 2008a, 2008b,2010, 2011; Rober, Elliott, Buysse, Loots and DeCorte, 2008a, 2008b; Seikkula et al, 2012]. Theory and practice development within this field can be understood as having two interrelated areas of interest. That is, understanding the nature of dialogue where the interactional phenomena and the emergence of the inter-subjective space is central [Bertrando, 2007; Rober, 1999, 2005a, 2005b, 2008c, 2008d; Sheehan, 1999]. And, dialogue between aspects of ourselves or the internal self-dialogue [Hermans, 2004a, 2004b, 2006; Rober, 1999, 2005a; 2005b, 2008a, 2008b; Seikkula et al, 2012 ; Stiles, 1999, 2007a; Stiles et al, 2004].

The internal dialogue concept, one aspect of the dialogical discussions, has I believe, gained a central position in Systemic inquiry. This concept will be central to this project. The nature of this mode of practice draws attention to the therapists multiple of internal voices and their relationships, which on acknowledgement can invigorate practice.

Rober [1999] introduced the internal dialogue concept into his impasse discussions[17]. As reported, Rober [1999, 2010, 2011] put forward reflexive ideas and practice models. Each description focuses on an articulation of the internal dialogue of the therapist with interest towards the experiencing-positions that emerge in response to the therapeutic encounter [Rober, 1999, 2010].

Rober's [1999, 2010, 2011] discussions advocate a move towards the therapist observing-of-self, and subsequently, a more enhanced therapeutic-use-of-self within the systemic environment[18]. These discussions, as noted prompted the development of the Dialogical Consultation Model.

This chapter will proceed with an introduction to the first draft of the model. This discussion is underpinned by the opening theoretical influences. The application of the model will then follow.

The Dialogical Consultation Model:

2.1. The overarching aims of the Dialogical Consultation Model:

The overarching aim of the first draft of the Dialogical Consultation Model was to externalise the internal dialogical activity of the therapist with the aim to observe and reflect on what the therapist brings to the therapeutic encounter [i.e. the therapists systemic reflections and professional directions], how they experience the therapeutic encounter [i.e. the here-and-now experiences and the historical-self as emergent in the therapeutic activity]; and, how they participate in the therapeutic encounter.

The task of this reflexive activity is to support the therapist to observe and study how they position themselves in the therapeutic activity,

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[17]Rober [1999], at first, portrayed the internal dialogue as a two–part concept [1999]. At that time, Rober [1999] proposed that the internal dialogue comprised of the experiencing-voice and the professional-theoretical voice. Rober [1999] suggested that the act of addressing the stuck encounter within the therapeutic environment can be enhanced by the therapist's observation and reading of both internal dialogical positions with some level of negotiation executed. Rober [2008a, 2008b, 2008c, 2009, 2010] extended the internal dialogue and observation-of-self discussions with increasing attention directed towards the therapist's experiencing and subsequent, positioning in therapy [2008a, 2008c, 2009, 2010, 2011].

[18] These discussions illustrate a shift in family therapy from the traditional interest in the mechanistic processes of the family to an interest in the therapist-observing-of-self in relation to their emergent self-dialogues, interpretation and response in therapy [see Elkaim, 1997; Jenson, 2007; Pocock, 1997, 2005, 2009; Rober, 1999, 2005b, 2010; Seikkula et al, 2012].

Moreover, in light of the theoretical influences[19], the model in practice endeavours to develop a consultation process and subsequent reflexive trajectory that by nature is an ongoing process that does not drive towards closure but rather towards a plurality of possibilities [see Sheehan, 1999, 2004].

To achieve this, the dialogical model aims to support the therapist to move through a number of sequential reflexive activities:

These sequential reflexive steps are as follows:

1. To support the therapist to observe, acknowledge and explore all their existing ideas and reflections that emerge as they participate in a client/family session and to treat all as worthy.
2. To support the therapist to move towards the development of a non-hierarchal cluster of reflections, or in systemic terms, the articulation of all professional and systemic ideas with the aim to develop an open, multi-positioned self-dialogue.
3. To support the therapist to move towards an enhanced insight into how they position themselves in relation to the identified client group through the exploration of the internal dialogue with emphasis towards articulating their experiencing reflections.
4. To support the therapist to move towards the development of a meta-reflexive position, [as developed through the externalising process], an activity which enables the therapist to view all ideas, reflections and self-experiences, and their relationships, in a more transparent environment, with the aim to work towards a community of linked observations that will create a multiplicity of thought and a flexible perspective towards the client group and the stories they share.

2.2. Objectives of the Dialogical Consultative Model:

1. The model introduces a structured way to support the therapist to observe their inner dialogue. This process aims to enhance the therapist's awareness of their dialogical-self and how they position themselves in the therapeutic environment.
2. The hermeneutic circle guides the model format. The aim is to promote an internal communicative process that encourages a back and forth movement between the professional, the systemic, the historical and the here-and-now-experiencing

[19] With reference towards the Dialogical-self-theories. This aim was initially influenced by the dialogical theories but as the project progressed it became a more prominent feature of the model in light of the introduction and incorporation of the ideas of Gadamer [1960/1990] into the model construction.

reflections, a reflexive process that encourages the therapist to look at each reflection, its position within the internal composition and how it responds with or interacts with the other ideas and observations etc. [see Rober, 1999].

3. By the use of phenomenological-dialogical framed questions, the model will offer to the participant an approach that steps into the experience of been stuck. The model questions will prompt the therapist to reflect on what they bring to the therapeutic encounter and therefore promote a more developed self-observation activity.
4. The Position Statements [see Cunha, 2007], will offer the therapist a meta-observational/reflexive position from which to step back or gain some distance from the stuck experience and the developing narrative of the experience as prompted by the consultation, observe their position, reflect, and *gather their thoughts* [selected highlight]. This reflexive activity will provide the therapist with an opportunity to evaluate and view alternative reflections and ways to proceed.
5. The dialogical model will include questions that aim to unsettle and challenge the therapists pre-existing portfolio of ideas and reflections, [and highlight the relationship between these dialogues] with the potential to prompt the emergence of new or different ways of reflecting on the stuck phase.

Application of the Dialogical Model:

2.3. What Will The Model Entail?

The Dialogical Model comprises of one consultation interview. This consultation entails the family therapist [i.e. research participant] observing and exploring the stuck experience that they are experiencing with the identified client group. For this project, by participating in the consultation, the family therapists are also requested to partake in a post consultation/post family meeting review.

The consultation model incorporates a number of sequential reflexive phases [see Appendix 7[20]]. Each phase has an aim that corresponds with the overarching aims and objectives of the model.

The model also incorporates the idea of a Position Statement [see Cunha, 2007]. The Position Statement concept entails the therapist formulating a specific personal sentence or reflection

[20] Appendix 8 introduces the first draft of the model and is followed by the amended drafts. Each draft includes notes on each reflexive stage of the model.

that will refer to their position towards the stuck phase. This statement aims to support the therapist to move towards a meta-observational position as described by Rober et al [2008a] by tracking changes of reflections and perspective. Over the course of the consultation, the therapist will be requested to formulate four Position Statements. Each statement will be recorded on a card and maintained in sight for reflexive purposes. The Position Statement is an important feature of the model. To the participating therapist it offers a meta–observational reflexive position [see Rober et al, 2008a, 2008b] from where they can observe how they reflect on the stuck experience, and, as the consultation progresses, it offers the participating therapist an opportunity to track any changes in their perspective or ideas. The task of the first Position Statement is to establish an initial perspective towards the stuck phase and support the therapist to move towards a meta-observational perspective as described by Stiles [1999] and Rober [2008a]. The task of the follow on Position Statements, are to develop the meta-observational position. Furthermore, in reference to the research aspect of this project the Position Statement will provide a baseline and developmental description of the therapist's observations, reflections and change of perspective towards the stuck phase.

2.4. When to use the model:

It is envisaged that the model may be of use when a therapist is experiencing a stuck phase in therapy. The model could be employed as a standalone therapist self-reflexive activity or could be introduced into their formal supervision. It is anticipated that this form of consultation or reflexive practice will compliment other forms [see Burham, 2005; Mason, 2012; Rober, 1999, 2010, 2011; Ungar, 2006]. In practice, it will give support to the therapist to express how they observe the stuck phase, how they engage with the client group, and from that position explore new or different ways to reflect or engage in the therapeutic process.

For this project, the participating family therapists were informed that the research consultation activity was a standalone reflexive activity that would not replace their normal supervision. However, the therapists were advised that themes that arose during the course of their research consultation could be introduced into their formal supervision if they felt that it would be useful.

2.5. How to introduce the model:

The internal dialogue concept encompasses a number of complex theoretical ideas, which I believe, are difficult to promote as a consultation process. Hermans [2006] recommended the "stage metaphor" as an uncomplicated way to explain the internal dialogue concept [Hermans, 2006, 329]. The idea is to equate the internal dialogue to a stage play, with the voices [i.e. in systemic terms: the ideas, reflections and hunches of the therapist] likened to interacting characters of a play that enter the stage at different times, alone, with other characters, having conversations with others, negotiating etc. This description of the internal dialogue will be introduced at the start of the consultation.

In addition, to support the effectiveness of the model it would be helpful if the consultant explains to the participants the meaning of the professional self, the systemic-self, and the experiencing-self. This introductory description will assist the participants to respond to the model questions in a manner that facilitates their own reflection in relation to the stuck encounter.

Furthermore, it would also be helpful for the consultant to explain to the participants the meaning of the "Position Statement" " [see Cunha, 2007, 302], and, its task in relation to the consultation, and, that as the consultation proceeds they will be requested to write the Position Statements on a card in order to view and reflect on[21].

3.1. Conclusion:

This chapter has looked at the first draft of the model.

The following chapter will define the research design and the selected methodology. In addition, the chapter will discuss the prejudices that I bring to this research. From that discussion, it will look at how prejudices can be addressed in research.

[21] See Appendices 8 and 9: The Dialogical Consultation Model in Practice.

CHAPTER 4:

THE RESEARCH DESIGN:

"...Out here there are no parameters...."
Morrison [1972].

1.1. Introduction: An outline of the research design:

This project will introduce a consultation model that has been designed to support therapists when they experience therapeutic stuckness in the therapeutic environment.
In research terms, it is interested in how the participants experience the model and if they consider it useful. Action Research methodology is about observing practice in a democratic manner with the aim to inform practice. This approach will direct the study.
In order to introduce and develop a new consultation model, and to understand its usefulness, the project is, first, interested in capturing how systemic therapists experience being stuck. Interpretative Phenomenological Analysis is concerned with participants lived experience and provides an approach that endeavours to develop a detailed analysis of the participant's individual experiences of the phenomena under investigation. This approach will guide aspects of the data gathering and analysis stage.
How should a researcher approach a project that they have a vested interest in? Critical self-reflexive methodologies [see Finlay 2002b] have emerged in recent years with heightened attention towards the position that the researcher holds in terms of the direction that the research dialogue pursues [Finlay, 2002a, 2002b, 2008; Frie, 2010]. For this project, in terms of my interest, a reflexive methodology becomes necessary for the validity of the project and thus, its description will be central to this chapter. Furthermore, the inclusion of a reflexive lens meets the requirements of an Action Research approach and an I.P.A. study.
To overview, Action Research will direct this study. The data gathering will entail family therapists engaging in and evaluating the introduced consultation model. The analysis will be directed through an Interpretative Phenomenological Analysis lens. A Gadamarian reflexive lens will oversee the project.
This chapter will continue with the aims of the project. The research questions will be posed. In response to the research questions, I will then introduce the research design. Validity and

rigour, and how both concepts can be understood in a qualitative study, will be reviewed. This particular discussion will include an outline of Gadamarian hermeneutics and will explore how this particular observational lens can support the development of a reflexive framework for use in qualitative research. The ethical and practicalities of the study will conclude this chapter.

1.2. The aim of the research project:

The evolving nature of systemic practice allows systemic theoreticians and practitioners to revisit systemic practice, to revise in terms of emerging ideas and at times rewrite core concepts[22]. The dialogical perspective brings to systemic practice a change in lens from which to observe practice phenomena. The dialogical framed model that this research project will introduce, aims to bring to the existing impasse discussions a practice suggestion that reflects current thinking and that may add to developed ideas.

1.3. The Dialogical Consultation Model: A synopsis:

The project will introduce a consultation model that is theoretically influenced by the dialogical theories and therapeutic-use–of-self ideas and investigate a therapist stuck phase through that lens. The chief strategy of the model is to introduce a reflexive consultation process that centers on illuminating the therapist's personal living self-dialogue in response to the therapeutic encounter.

The aim of the project has been defined. In response to the aim and in order to move forward with the project and to establish how to position the inquiry frame it is necessary to formulate research questions:

The research questions that will frame this inquiry are as follows:

1.4. Research Questions:

1. In what ways does a Consultation Model influenced by the dialogical theories influence a therapist who is experiencing a stuck phase?
2. What can be learned from this to advance the consultation model?

[22] The systemic identity continuously moves by absorbing different views and ideas with a number of notable theorists and practitioners providing theoretical interpretations that prompted seismic shifts in practice. See for example Andersen [1995], and, White and Epson [1990].

How can we address these questions? The following discussions will look closely at the research trajectory. Through this discussion, I will identify how the research will be conducted and how the data will be analysed. These discussions will spell out how the research questions will be addressed.

The Research Trajectory:

2.1. Action Research Methodology as a systemic development of understanding:

An introduction:

This section will commence with a description of Action Research.

Action Research is an evolving inquiry form with variations in its philosophical base and application and thus various interpretations emerging. It is therefore difficult to locate an overarching definition that fits all. In light of the evolving nature, existing definitions focus on characteristics. Therefore, my definition is underpinned by characteristics. Action Research is characterised by a reflexive/action cyclical framework. The discussion will describe this cycle and introduce the cyclical framework that will guide this study. An overview of how to assess the quality of a qualitative study will complete the opening discussion.

Additionally, Action Research advocates collaboration[23] between the researcher and the research participants and places a strong emphasis towards a researcher-position of openness or responsiveness to the ideas that are shared in the research dialogue. In correlation with this frame of collaboration and openness, Action Research as a research approach highlights the need to incorporate a researcher reflexive lens. The reflexive framework that has been designed for this project will complete this discussion.

2.2. What is Action Research?

Action Research is a form of qualitative research that sets a goal of addressing an identified problem or practice in the workplace or social setting [McNiff, 2002; McNiff and Whitehead, 2009; O'Brien, 2001; Reason, 1994; Reason and Bradbury, 2006]. The methodology of

[23]The move towards a relationship style that embraces collaboration, democracy and fairness between the researcher and participants in Action Research, and, more recently in Participatory Action Research, can be understood as an evolving dialogue. Originally, the relationship styles were equated to a continuum of levels of participation and collaboration. Space will not allow me to fully develop this evolving discussion [see Arnstein, 1969; Gustavsen, 1992, 1996, 1998; Habermas, 1984, Reason and Bradbury, 2006].

Action Research is characterised by a systematic cyclical method of observing the identified problem or aspect of practice, planning the intervention, taking action, evaluating the action, modifying the action, planning the follow on action, and subsequently repeating the revised activity until a time that it is considered that the outcome has been reached. Each cycle informs the next cycle. A researcher reflexive lens[24] overarches the activity with the aim to bring forth the personal text of the researcher and observe how it connects with the research participant's experience of the research activity.

Similar to other qualitative approaches, overtime-different Action Research methodologies have evolved [Kemmis and McTaggart, 1998, 2005]. These methodologies evolved in order to reflect the shifts in philosophical thought and the emergence of the various ontological and epistemological positions [see Flood, 2006; Hall, 1981; Reinharz, 1992]; and, to address different research tasks [see Weiner, 1989].

2.3. Why direct the project through an Action Research lens?

The aim of this project is to introduce a Dialogical Consultation Model. The model is a work in progress. Prior to the research activity, the model, its theoretical base and format, was directed by the literature and the researchers own clinical experiences. To advance the model it would be necessary to put it into practice. Through that activity, the suitability, effectiveness and limitations of the model can be addressed. Action Research provides a methodology that can address that activity.

Kemmis and McTaggart [2005] state that Action Research is distinguished from other forms of research by the fact that researchers are investigating their own practices. Furthermore, and reflective of systemic thinking, a number of writers report that unlike many other research and development approaches, Action Research does not want to replace the practitioners thinking by expert knowledge but rather aims to build on it and to support it [Kemmis and McTaggart, 2005; McNiff, 2002; McNiff and Whitehead, 2009]. As I reported, systemic theory and practice can be described as an evolving inquiry lens. It features a complex historical field and a multifaceted contemporary identity. It embraces a kaleidoscope of ideas and practices, both traditional and those more fitting with the new horizons of understanding [see Bertrando, 2007]. It is not possible to delineate the traditional from the contemporary

[24] I suggest, that this reflexive activity can be described as a balancing act, which works to hold collectively, the multiple of perspectives, where each voice is witnessed, addressed and at times, challenged [see McNiff, 2002; Reason, 1994; Willig and Stainton-Rogers, 2008].

mode of inquiry. I believe, each wave of inquiry learnt from and built on what went before. Therefore, to separate practices would be an unproductive activity. As reported, this project will introduce an alternative model. It is not to replace previous ideas and practices, but, to build on and offer a wider repertoire of skills to practicing therapists. Once more, Action Research provides an approach that can address this activity.

2.4. What form of Action Research will direct the study?

For this project, I had hoped to direct the study through a Participant Action Research methodology [P.A.R.]. Participatory Action Research can be defined as an inquiry process where all involved parties are actively engaged and work in collaboration to bring about a synergy of perspectives and ideas that influence the research process [McNiff, 2002]. I was interested in P.A.R. because its ethos and application to research fits with current systemic ideas. Certain aspects of this project did fit with P.A.R., namely, the consultation process and the post consultation dialogue. However, core aspects of this project did not fit with P.A.R., namely, the initial development of the model; and, during the course of the project, the model amendments and technical changes. I carried out these two aspects in response to the literature, my ideas, and my observation of how the participants engaged with the model.

Thus, it would be more accurate to report that the project was conducted through an Action Research lens.

However, this research dialogue has provided an interesting discussion. It has posed a number of interlinked questions, namely,

How do I, as a systemic practitioner, understand and engage with research?

And,

From a systemic lens, how can we describe and engage in collaborative research [see Flood, 2006]?

This theme will be revisited at the close of the project.

2.5. Why use Action Research?

To justify the use of a research methodology calls attention towards how it fits with the philosophical direction of the project, and, how it fits with the research question and task. The following discussion will look at how Action Research lends itself to this research inquiry:

Action research evolved from a number of disciplines, namely: social psychology [Lewin, 1946; Reason and Bradbury, 2006], critical theory [Habermas, 1984], anthropology [Goodenough, 1963; Mayo, 1933], and feminist literature [Hall, 1981; Reinharz, 1992]. The

more recent variations in Action Research e.g. Participatory Action Research, are influenced by phenomenology, post modernism and hermeneutics [see Gummesson, 1991], and, a gathering interest in systemic thinking [see Flood, 2006]. Its contemporary expression illustrates values and principles drawn from these disciplines, with marked attention towards collaborative participation, democracy and ethical fairness [Kemmis and McTaggart, 2005]. These values reflect how current systemic practice is described in literature and reflect the values that I, as the researcher and as a practicing systemic practitioner, would endeavor to emulate during the course of this project.

Furthermore, research as an activity, has witnessed shifts in practice from a theory driven activity to a practice driven activity. This shift highlights the relationship between the researcher and the participants. Action Research acknowledges these shifts. As a research activity, Action Research moves beyond this acknowledgement and declares that unless people can talk in a democratic way to each other no new ideas are possible [Gustavsen, 1992, 1996, 1998]. In order to address the task of this project a democratic relationship is necessary. Action Research advocates that aspect of research.

In relation to practice, Action Research is an experiential and reflective action orientated methodology that lends itself to testing new ideas [see Reason and Bradbury, 2006]. Furthermore, through the planning - action - systematic reflection - challenges of interpretations cyclical process, it has the potential to diminish the gap between theory, research and practice. Hence, from these two points, Action Research has the potential to generate outcomes that are relevant and useful to practice.

Moreover, in relation to the inquiry process, this research provides an opportunity to explore an alternative consultation approach to therapist stuckness. My role as researcher is twofold. To begin with, my role is to engage family therapists who encounter a stuck phase in therapy in a consultation that is framed by the dialogical perspective, and, from that activity, examine how the therapist stuck phase responds to the dialogical consultation. This task requires a research approach that will focus both on the defined practice in a tangible way, and, how that practice responds to an intervention. Action Research provides an action/reflexive cyclical framework that will address both tasks [see Reason and Bradbury, 2006].

Thus, on all of the above accounts, Action Research is a research approach that corresponds with the projects philosophical lens, and provides a methodology that can respond to the research questions and task.

With Action Research as the selected design how will the research be conducted? This question will now be addressed.

2.6. Action Research in action:

Action Research generally follows a sequence of action/reflexive cycles [see Checkland, 1992; Kemmis and McTaggart, 1988, 2005] that draws on a number of data sources.

The data sources include:

I. The literature at pre inquiry phase in order to develop a baseline understanding and a revisiting of the literature during the course of conducting the research in order to explore themes that arise.

II. The collaboration between the participants and the researcher.

III. The researcher's self-reflexive lens. Although the researcher's self-reflexive activity appears to be a solitary process and does not appear to fit with Action Research, on reflection of Gadamer's [1990/1960] reading of the complex relationship between prejudice, dialogue and the emergence of new understandings; some of the earlier feminist thinkers who partook in the Action Research dialogue [Daniels, 1983; Scheper-Hughes, 1992]; and, the inclusion of systemic thinking into the Action Research literature [see Flood, 2006], the researcher's self-reflexive lens is a central component of Action Research[25].

As noted, the inquiry trajectory is cyclical in nature. For this project, the cycle moves between the researcher observing current theoretical and practice ideas in relation to therapist stuckness, using this information to instigate the development of the model, requesting family therapists to partake in the project, engaging participants in a consultation directed by the dialogical model, observing how the participants experienced the model, exploring with participants how they experienced the model, and subsequently, the researcher reflecting on the activity with attention towards how to proceed.

With the completion of each consultation, the task for the researcher is to reflect and draw lessons from the preceding action with interest towards:

<u>Action Research inquiry lens:</u>

What do we now understand about the model in practice?

What worked?

[25] I believe this reflexive activity can lead to a more authentic form of collaboration between the researcher and the participants.

What did not work?
Would it helpful in light of the aims of the model to amend technical aspects of the model?
Would it be helpful to revisit how I, the researcher, understand the research process and how I, position myself in the research activity?
How will we proceed?

Any changes that are executed are informed by the collaboration between the research participants and the researcher's responsiveness towards the emergent research dialogue. This cyclical activity can be understood as a hermeneutic spiral rather than an iterative process. The hermeneutic cycle provides greater depth of evaluation [see Gummesson, 1991], where each turn of the spiral builds on the previous turn, and observes this relationship in terms of *the whole project* [selected highlight], providing the researcher with new sets of questions, new insights or new ways of proceeding [see Smith, 2004; Smith and Osborne, 2003; Smith, Flowers and Larkin, 2009].
A reflective/action research plan, as underpinned by the Action Research design, was drafted [see Coughlin and Brannick, 2005; McNiff and Whitehead, 2009] [see Appendix 5]. This format guides the project. It follows the Action Research cycle. Action Research as research methodology brings with it a contemporary disposition. It draws on post modernism, dialogue and a leaning towards systemic thinking. This synergy of ideas calls to attention the principles of dialogue and its place in research. However, Action Research has attracted some criticism of which, I, will now discuss.

3.1. Criticism of Action Research:
Action Research has attracted criticism regarding its assumptions, design, measurement outcomes and the role of the researcher. Additionally, and more specific to the emerging variations of Action Research, its participative ideology has gathered ongoing academic critique [Arnstein, 1969; Habermas, 1984; Kemmis and McTaggart, 2005].
The following discussion[26] will address three criticisms, which I believe are central to this project:
<u>Criticism 1:</u>

[26] This discussion is underpinned by Yardley's [2008] and McNiff and Whitehead [2009] description of how to assess the quality of a qualitative research project.

Firstly, critics argue that the methodology of Action Research is unclear, experiential, and, is thus, a haphazard process. To address this criticism, I have put forward an action/reflexive framework presented in a sequence of action/reflexive steps [see Appendix 5]. Other sources of internal and external validity and rigour that are evident in an Action Research, and are accordingly evident in this project will be identified. In correlation with the action / reflexive sequence framework, they strengthen the quality of this project.
They are as follows:

Sources of validity and rigour:

To present a convincing study a number of measures need to be built into the research design and write up.
This project includes these measures.
First, the selected sample must be appropriate. Thus, for this project, systemic family therapists were selected for the conducting of this project. Each participant was familiar with the existing systemic discussions and therefore engaged in the consultation in a meaningful manner.
Second, the interview must reflect sensitivity to the context through knowledge of the existing literature and contemporary practices in the defined area. In response, the interviews entailed the participants engaging in the dialogical model as developed through the literature and contemporary practice suggestions.
Third, quality research must demonstrate sensitivity to the interview and how it is executed. Each therapist who consented to partake in the study was offered the opportunity to select the time and place of the interview. They were advised of the probable length of time of the consultation and advised of the sensitivity of some of the consultation questions.
To conclude, the completeness of the data analysis and sufficient idiographic engagement in the write up are necessary measures to ensure research quality. This project incorporates an Action Research, a Phenomenological and a Gadamarian Reflexive lens. This multiple observational lens supports a comprehensive multi-positioned analysis of the generated data. Through the course of this project and the write up, I have carefully observed each consultation with an in-depth engagement with the emergent themes. This observation is demonstrated in the analysis chapters [see Chapter 6 and 7]. In addition, how I engaged with the data and how the emergent themes developed through the course of the research trajectory is illustrated in Appendices 6 and 7.

Criticism 2:

The participation continuum:

A number of writers have suggested that Action Research is characterised by a participation continuum representing levels of participation i.e. from a co-option form of participation to collective action form of participation [see Arnstein, 1969; Gustavsen, 1992, 1996, 1998; Reason and Bradbury, 2006]. It can be argued that, as participation increases so do the opportunities to use participants as a source to challenge each other and to challenge the researcher's assumptions of the research task, the research design and the interpretation strategies and outcomes. Most forms of Action Research seek higher levels of participation than other research designs [see Swepson, 1998]. For this project to be useful, it required the participation of practicing family therapists, and more pointedly, their views regarding the effectiveness and suitability of the model in practice. Five family therapists engaged in this project. Their engagement with the model, their participation in the reviews, and, their feedback, was an essential aspect of this research. This participation strengthens the validity of this project.

The participation level aspect of this project has the potential to attract criticism. Action Research, as we understand, calls for a collaborative form of engagement between the researcher and the participants. It can be put forward that this form of engagement was not always actively sought during the course of this project.

To defend the manner in which I conducted this project I put forward the following arguments:

I. This project introduced an alternative consultation model. The draft that was introduced was a template waiting to be tested and modified accordingly. The testing and modification process required engagement, participation and active critique by the participants. Therefore, that stage of the research reflected an Action Research approach.

II. I conducted the development of the initial template, in response to the literature. The pilot study again involved my participation. These stages did not fit with the Action Research approach i.e. if we observe it from a contemporary perspective. The argument that I put forward is that for different ideas or for different ways of observing existing ideas or practices to germinate or evolve, they require either a uniqueness of thought or an idiosyncratic way of reading the ideas of others. Uniqueness brings difference. Difference brings new ways of looking at familiar

practices. Through that process, the model was initiated and further developed. How does this argument fit with Action Research? Returning to some of the earlier academic descriptions [see Arnstein, 1969], participation can be understood on a continuum that identifies a shifting level of participation identified as a co-option form, a consultation form, a cooperation form, a co-learning form and a collective action form. For the conducting of this project, I moved through the various forms of participation in order to create a research environment that ensured attentiveness to the input from the participants, a process, which enhanced the appropriateness of the developing ideas. In addition, I took time out from the participatory milieu in order to gather my thoughts, for two reasons, firstly, to initiate the development of the model, and secondly, to identify how best to move forward. This shifting participant mode, I believe, enhances the quality of this project and is a suitable approach at this stage of the models development. I will return to this idea at the close of the project.

Criticism 3:

Finally, to complete this discussion on how Action Research can attract criticism the final topic will look at how the researcher is positioned in the research process and the possible influence of prejudices.

It has been argued that Action Research is an inherently biased activity with academic interest directed at the lack of division between the researcher, the participants and the research activity [Greenwood and Levin, 1999; Swepson, 1998]. For this project, I endeavour to introduce another approach to stuckness. It could be argued that my vested interest in the model and my direct participation in the project provides me with a motive to influence the inquiry process i.e. to not provide the space to develop participants discussions or to restrict contradictory feedback [see Gustavsen, 1992; Habermas, 1984], and subsequently, influence the outcome. This is not an original concern. Action Research as an inquiry form acknowledges this risk [McNiff and Whitehead, 2009]. In response, I have incorporated a reflexive framework. Gadamerian hermeneutics will guide the reflexive format.

This chapter will continue with a look at the prejudices that I bring to this project and in response a discussion on the Gadamarian reflexive framework that has been formulated for this inquiry.

4.1. The researcher's epistemology:

This project touches on the living experiences of family work. The participants, and I, the researcher, will witness together the family stories. Is it possible for me to remain detached?
In addition, I have invested time in the development of the model. The position that I adopt during the course of the research will that be swayed by my vested interest? The emergent dialogue during the course of the research, will that be swayed by my prejudice? The evaluation of the model, again, will that be swayed by my prejudice?
Furthermore, in correlation with the development of the dialogical model and my interest in its effectiveness, I bring to this project a more fixed prejudice. I believe that therapist-observation-of-self is central to theory development and practice in contemporary systemic practice.
To assume that the research process will be uninfluenced by my interests reduces the validity of the study. What I bring to this project has the potential to obscure the participant's view of the Consultation Model. Openness, understood as the articulation of all prejudices, preconceptions and emerging understandings, becomes central.
In response to the posed questions and disclosed prejudices, this chapter will proceed with a discussion on how to position prejudice in research and in relation to my position as the researcher, how I can remain curious about the model and its value in practice.

4.2. Reflexivity as a component of qualitative research:

Qualitative research has experienced continual philosophical, and linked, theoretical revisions [For example see Smith, Flowers and Larkin, 2009]. In correlation with these revisions, the research process has experienced various amendments and elaborations [see Holm and Severinsson, 2010]. These adjustments, I believe, amongst other influences, can be indebted to the reading of Hans-Georg Gadamer [1976; 1990/1960], who, extended hermeneutic thinking by introducing the reciprocal dimension of understanding and interpretation [Smith et al, 2009; Frie, 2010; Frie and Orange, 2009][27].
In response to the shifting philosophical views, there is a growing movement within the research community to shift from an approach that endorses a researcher-participant division,

[27] In addition, the ideas of Bakhtin [1981, 1986] and the growing interest in dialogical philosophy have contributed to the shifts in the theories of meaning making and understanding.

towards a research trajectory that endorses a closer observation of the inter-subjective space and its role in the research process [Finlay, 2002a, 2002b, 2008; Frie, 2010][28].

Gadamarian Hermeneutics [1990/1960], in the context of research, directs attention towards pre-conceptions and highlights how they can limit reciprocity and openness to the other, if not addressed and integrated into the evolving meaning making process [Smith et al, 2009; Frie, 2010; Frie and Orange, 2009].

It is anticipated, that a reflexive framework guided by Gadamarian [1990/1960] concepts is best suited for this project. The aim is to put forward a systematic frame of reflexivity that promotes an interacting dialogic process, between what the researcher brings to the project, what the participants bring to the project, and how the researcher observes the emerging research dialogue.

Thus, Gadamarian hermeneutics will be introduced with a discussion on the Gadamarian ideas that will be utilised and a discussion on how they translate to research.

4.3. What is Gadamarian Hermeneutics?

> "Our understanding of the other is always achieved through the lens of our own situatedness..."
> Gadamer, [1990/1960, 143].

Hermeneutics can be understood as a continuum of ideas or a moving dialogue about the "craft or art" of understanding and interpretation [Smith et al, 2009, 22]. Why Gadamer[29] [1976, 1990/1960]? This theorist highlighted the enabling factor of pre-conceptions and brought forward the social dimension of understanding and interpretation, from which, I argue, hermeneutics experienced not necessarily a re-conceptualisation but a refocusing of

[28] Similarly, contemporary systemic thinkers strive to carve an approach that endorses a "joint spontaneous involvement" [Goffman, 1967, 113] between practitioner and client group, a dialogical interplay that endeavours to create an openness to a genuine dialogue and from that engagement a synthesis of ideas rather than a directed intervention [see Rober, 1999, 2005b].

[29] I do appreciate that to focus solely on one theorist does not allow the complexity of the theories to stand out and more importantly, how the continuum of ideas developed. One example is the development of the theoretical description of the concept of biases, prejudices or fore structures and linked process of bracketing [see Smith et al, 2009].

ideas and application. My aim is to translate Gadamarian [1990/1960][30] ideas to research and develop a tangible, systematic reflexive format that takes account of the multiple narratives[31]. In order to translate Gadamarian ideas from an abstract form to a more tangible mode suitable for use in research, it necessitates a number of steps. Firstly, I will identify the ideas of Gadamar [1976, 1990/1960] that will support this research project. The ideas will then be expressed in terms of their position in the context of research. Following that, the ideas will be expressed in terms of reflexive domains with correlated reflexive questions. These reflexive questions will form the reflexive framework.

4.4. Gadamer's Ideas:

I. <u>The positivity of prejudice</u>:

Gadamer [1990/1960] highlighted the importance of historical understandings or prejudice[32], which followed closely with the earlier ideas of Heidegger [1962/1927][33]. However, Gadamer [1990/1960] rebuked the negative connotations often linked with prejudice and argued that rather than bracketing, our prejudices are themselves what opens us up to our existing cognitive parameters, and from that observation, open us up to observing differences. Thus, Gadamer [1990/1960], described interpretation as a dialogical interplay or as a "thoughtful mediation" [1990/1960, 169] between the pre-conceptions, the emergent structures and new horizons in response to the other.

II. <u>The reciprocal dimension of understanding and interpretation:</u>

Hermeneutics, and the linked interpretation techniques, were originally developed to aid the interpretation of complex and often incomprehensible texts such as the bible [Smith et al, 2009]. Originally, the key interpretative technique, the hermeneutic circle, was conceived in terms of the relationship between the whole text and its individual parts. The social or reciprocal dimension of understanding and interpretation was not originally a fore concern.

[30] I have read Gadamerian hermeneutics from a research position. Yet, hermeneutics has been engaged with and informed by other disciplines and other concerns. Thus, my interpretation is open to critique.

[31] A number of authors have explored Gadamerian concepts and how they translate to research. The aim of this discussion and formulation is to develop a reflexive model that draws on the ideas of Gadamer and to include some aspects of the earlier descriptions and translate them into tangible steps appropriate for a research activity [see Koch, 1996; Fleming, Gaidys and Robb, 2003].

[32] In relation to this concept, Heidegger [1962/1927] used the word pre-understanding. Gadamer [1990/1960] used the word prejudice, but with a positive connotation in contrast to the earlier theorists like Heidegger [1962/1927].

[33] For a comparative study, see Larkin, Watts and Clifton [2006].

Gadamer's [1990/1960] ideas extended the application of the hermeneutic circle interpretative technique from the interpretation of texts to a systematic interpretative process that observes the trajectory of understanding and interpretation as a dialogic, situated activity. To read Gadamer's version of the hermeneutic circle, in the context of research, dialogic understanding and interpretation is a process of firstly, the researcher observing and mediating between their fore structures, their initial meaning and fore projections, and subsequently moving into the dialogical lens, encompassing both their own horizons of understanding and the participants, with a continuous ebb and flow between the multiple levels of understanding.

4.5. To translate Gadamarian [1990/1960] ideas to the research process:

To engage with the Gadamarian ideas in a research environment directs our attention towards two frames of interest:
Firstly, the researcher observes his or her *own* historical preconceptions in terms of the research theme [selected highlight].
And secondly,
The researcher observes the changing nature of their horizon of understanding and the participants` horizon of understanding and how it moves into a continuum of revising in response to the research encounter, and the cyclical process of hermeneutic listening, meaning making and interpreting.

To translate the two frames into the research domain, the next step is to translate to reflexive domains:

Reflexive Domains:

I. Differentiate frames of reference of researcher and research participant.
II. Exploration of preconceptions.
III. Exploration of evolving interpretations of both researcher and research participants.
IV. Exploration of the relationship between the evolving interpretation of researcher and participant.
V. Exploration of the evolving co-constructive dialogue.
VI. Exploration of both parties influence on the evolving dialogue.

To bring the reflexive domains into the research trajectory, reflexive questions have been developed. The questions will form the reflexive framework. Although the framework suggest a step-by-step process, the reflexive process, again to be consistent with Gadamarian ideas, is to endorse a continuous back and forth movement between all frames of reference and between all levels of reflection, as described in the horizons of observation, and, the hermeneutic circle concept [see Alvesson and Skoldberg, 2005; Caelli, 2000; Finlay, 2002b; Frie, 2010; Frie and Orange, 2009; Smith, Flowers and Larkin, 2009]:

Table 2: Reflexive Framework as guided by Gadamerian Hermeneutics: [1990/1960]:

Domains:	*Reflexive Domain:*	*Reflexive Questions:*
Domain One:	Researcher Self-Reflexive Dialogue: [Researchers horizons of understanding]	"What do I bring to this inquiry?" "Am I open to my existing understanding of the research theme and suggested approach?" "Am I open to what I may observe during the course of the research?" "Am I engaging in any emergent shifts in understanding?" "What can I add to this inquiry?" "What do I hope to bring from the inquiry?"
Domain Two:	Reflection on meaning making trajectory of research participant: [Participant horizon of understanding]	"What do the participants' bring to the inquiry?" "What is their existing understanding of the research theme?" "How do they observe the suggested approach?" "How do they engage with the model?" "What do they bring from the inquiry?"
Domain Three:	Intersubjective Reflection: [Reciprocal interpretation]	"Are both parties open to reflecting on the horizon parameter or bias perspective of the other?"

		"Negotiating process: Are both offered the opportunity to move into a frame of mutual reflection?" "Does the interview process provide a dialogical space for the introduction and mutual exploration of different, new or conflicting ideas or reflections?" "Does the interview process move towards a "not knowing" position [Gadamer, 1990/1960, 383], open to uncertainty?" "Do the horizons of understanding shift or accommodate new meanings or co-constructed meanings?"
Domain Four:	Critical Self-Reflexivity [Researcher]	"What is my role in the consultation process?" "Do I impact constructively and without prejudice on the research dialogue and emergent dialogues?" "Do I camouflage my vested interest?" "Do I manipulate the research dialogue?" "Am I open to contradictory positions?"

4.6. What will this reflexive model add to the project?

I believe the inclusion of the ideas of Gadamer [1960/1990] into the project will provide a research platform that promotes an open, transparent dialogue that engages with the theme comprehensively. Although Action Research supports a co-constructive mode of inquiry, on reflection of the selected level of participation for this project and the prejudices that I hold, the inclusion of this strand of hermeneutics will ensure a critical level of reflexivity, a process that will support a higher level of transparency.

In summary, I have described how the research will be conducted and explained how I will incorporate a reflexive lens into the project. However, this project is interested in how participants experience an alternative form of consultation. Therefore, the data gathering and

analysis section must also include a lens that will observe that area of interest. Interpretative Phenomenology Analysis [I.P.A.] has been selected to carry out this task.
The following discussion will introduce this observational lens and look at how it will be conducted.

5.1. Interpretative Phenomenology Analysis and Correlated Analysis Framework [see Benner 1984; 1994; Smith, Flowers and Larkin, 2009]:

> "What is essential in the phenomenological observation is that one never glimpses an isolated phenomenon. Rather the phenomenon always presents itself against the background of an I, of a person".
> Binswanger [1975/1963] cited by Frie [2010, 79].

The Dialogical model, its theoretical discussions, and, its usefulness in practice, has the potential to dominate this project. However, what remains important is that this project primarily strives to understand how research participants experience stuckness within the realm of family therapy and subsequently, how they experience the dialogical model. Interpretative Phenomenology offers a philosophical underpinning and aligned methodology that responds to that task. It provides a model that allows the researcher to observe how the participant experiences the world of stuckness, and how they experience the dialogical model, without automatically reverting to theoretical explanations or reducing its expression to disconnected descriptions.

5.2. Interpretative Phenomenology Analysis:

Interpretative Phenomenology Analysis [Smith, 2004, Smith and Osborn, 2003; Smith et al, 2009], as guided by Gadamarian Hermeneutics [Gadamer, 1976, 1990/1960], will direct the data gathering and data analysis stage of the project in conjunction with the other introduced lenses. Phenomenology analysis, to be consistent with the Gadamarian lens, will observe the participant's experience of the research theme through the process of moving from observing their pre understanding, to observing their emergent dialogue as they engage with the model, to observing their understanding post engagement with model. This movement will help to elicit the participant's relationship with the theme as they move from pre-understanding to post engagement with the model.

5.3. The Analytic Trajectory:

A number of questions will guide the analytic trajectory for this phenomenological study:

Pre Dialogical Model and pre client group meeting:
What meaning do the participants ascribe to the projects theme i.e. therapist stuckness, in response to the opening phenomenological based question?

Dialogical Consultation phase:
How do the participants experience and engage with the dialogical consultation?

Post Dialogical Model and post client group meeting:
How do the participants describe their experience with the Dialogical Model?
What meaning do the participants ascribe to the projects theme in response to their engagement with the Dialogical model?
What meaning do the participants ascribe to the projects theme on reflection of their opening description?

5.4. The Analytic Process[34]:

The analysis will follow a number of stages. The above questions will guide the stages of the analysis:
Stages of analysis: The analysis is to commence with a full reading of the each consultation and post consultation review transcript to develop an overall gestalt [Benner, 1984, 1994; Smith and Osborne, 1999; Smith et al, 2009]. Each transcript is to be completed before following transcripts are commenced. The first task is to identify the themes introduced by the participants as guided by aforementioned questions [Smith and Osborne, 1999; Smith et al, 2009]. The next task entails developing a brief summary of emergent themes, looking for connections and developing cluster themes. The development of super-ordinate themes follows; a process that brings together the identified related themes [Smith et al, 2009]. The final stage entails the move towards developing a gestalt of the super-ordinate themes [Smith and Osborne, 1999, Smith et al, 2009]. At the completion of all the research interviews, all

[34] If I.P.A. was a standalone methodology, it would be essential to include a critical reflexive layer, "a close observation of the intersubjective space" [see Smith et al, 2009, 52].

themes are to be compared with attention towards patterns across participants themes and differences [Smith et al, 2009] [See Appendices 6 and 7].

The research design has been described. The following section will look at the ethical considerations applicable to this project and then complete this chapter with a look at how the practical aspects of the research journey commenced.

6.1. Ethical considerations:

The plan of this research project was submitted to the Research Ethics Committee at both the University of East London and Tavistock and Portman NHS Trust, and approved by both [see Appendix 12]. Following that approval, I corresponded with the Family Therapy Association of Ireland [F.T.A.I.] in order to request permission to access their membership database with the aim to recruit systemic therapist [see Appendix 1]. Permission was given. The information leaflet was subsequently forwarded to members of the F.T.A.I. The leaflet provided a brief description of the project and what participating entailed [see Appendix 2]. Interested parties were informed that they could seek further information or clarification, if required, prior to making the decision to participate or not. Each interested party was requested to sign the informed consent form before participating in the project [see Appendix 3].

Prior to participation, all participants were informed that due to the research theme, the generated data would include idiosyncratic stories of families that the participants have the opportunity to meet with on a professional basis, and that in congruence with research ethical parameters and systemic practice parameters, confidentiality and anonymity was essential. The participants were informed that names, dates, locations and idiosyncratic descriptions would be omitted from transcripts, analysis and outcome discussions. Furthermore, the participants were informed that the collected data was to be held in a locked press in the principal researchers work office and that only the named supervisors and researcher would have access to data and that the transcription of data would be completed on principal researcher's computer with no other person having access to the computer.

Therapist stuckness as a theme in research would entail the researcher disclosing family narratives. The research participants were informed that in order to participate they would firstly, have to discuss with the identified client group [that may be introduced into research] the research topic and process, with the client group owning the decision to have their stories included or not into the research project. If the client group makes the decision to have their

stories included in the research, they are to be requested to sign an informed consent form [see Appendix 4].

6.2. Ethical issues that emerged during the course of the research:

Therapist stuckness, as a discussion, raises sensitive themes, as I have found during the course of this project. By engaging in this project, the participants were invited to explore and reflect on their own practice i.e. their engagement with client groups. This process has the potential to influence them as practitioners and may change their personal and professional perspective. Therefore, my role as the researcher, and participant in the consultations, was to firstly, ensure that the participants were fully informed of the aims of the project and their part in the research; and secondly, my role was to distinctly respect the shared stories and to ensure confidentially at all stages of the research process. To ensure confidentiality, each participant was allocated a pseudo name. In addition, as noted, all names, locations and idiosyncratic themes were removed from the transcripts and discussions.
On reflection of the consultations, and the many stories shared, it brings to mind not only the complexity of systemic work but it reminds me of the time and trust that the participants invested in this project.

The start of the research journey...

With permission to conduct the project granted, the first task was to recruit.

The following section will step through that process.

7.1. The recruitment process:

The participant recruitment process was designed to recruit clinicians specifically from the specialist field of Systemic Family Therapy. A letter was forwarded to the acting chairperson of The Family Therapy Association of Ireland [F.T.A.I] to request ethical approval and to request access to the F.T.A.I. member database [see Appendix 1]. The aim of this recruitment process was to attract clinicians who have in-depth knowledge of Systemic Family Therapy, are familiar with existing systemic practices and the current direction in this specialist field. This request was forwarded to the research committee of the F.T.A.I. The committee stated that the family therapy database was a public domain and therefore permission to access was automatically approved. In response, information leaflets were forwarded to F.T.A.I. members.

7.2. Sample size:

In reference to the complexity of the consultation format and in order to promote the idiographic nature of a phenomenological study, a sample size of five was sought for the project. Previous studies directed through the same lens, selected small sample sizes and on inspection have developed detailed data [Clare, 2002, 2003; Mcilfatrick, Sullivan and McKenna, 2006].

7.3. The participants:

The recruitment process was slow with a poor response. In discussion with a small number of family therapists prior to the research, they reported that they were uncomfortable with a structured consultation and felt that it did not necessarily fit with current systemic thinking. Fortunately, six family therapists agreed to participate. Regrettably, because of a poor quality of recording, the first consultation was discarded. The remaining five candidates took part in the consultation and kindly took part in the post consultation/post client group meeting review.

7.4. Details of participants:

Table 3: Details of participants[35]:

Name and profession:	*Workplace:*	*Experience as family therapist:*
Teresa, Psychiatric Nurse.	Child and Adolescent Mental Health Services.	3 years.
Michael, Principal Social Worker	General University Hospital.	15 years.
Kathleen, Social Worker.	Child and Adolescent Mental Health Services.	1 year.
Elizabeth, Social Worker.	Child and Adolescent Mental Health Services.	10 years.
Johanna, Clinical Psychologist.	Private Family Counselling Service.	5 years.

[35] Pseudo names used.

8.1. The consultation process:

All consultations were conducted in the participant's place of employment except one candidate who requested the consultation to be held in her private home. Consent was obtained from all participants. In addition, all participants discussed with their identified client group what taking part in the project would entail and how confidentiality would be maintained. Consent was requested and received from all client groups. Each consultation was recorded on a Dictaphone and transcribed by the researcher. Confidentiality was maintained at all times.

9.1. Closing note:

Norlyk and Harder [2010] examined phenomenological directed studies. They identified that many studies name a philosophical and theoretical lens that will lead their study, describe what has to be done in reference to the selected lens, but most often do not translate the ideas to practice. I do understand that this chapter is lengthy. However, I believe in terms of research quality, it is essential to clarify how I will conduct the study and how I will engage with the research dialogue.

The following section will describe each conducted consultation with an inclusion of the analysis. The analysis will move between a phenomenological observation and a Gadamarian evaluation, the outcome of which informs the Action Research. The Action Research lens influences how the model progresses. The task is to observe stuckness in systemic therapy, evaluate the effectiveness of the dialogical model and further develop.

SECTION B:

THE RESEARCH JOURNEY AND HOW IT UNFOLDS, THE ANALYSIS TRAJECTORY WITH AN EXPLORATION OF THE EMERGENT THEMES.

Orientation to Chapters 5-7:

Section B contains three chapters. Chapter 5 introduces the research journey. The pilot interview will form the backdrop to the discussions in this chapter. In Chapter 6, the research journey continues with a close observation of the five research consultations. Chapter 6 brings together the phenomenological, Gadamarian and Action Research lens. Chapter 7 will introduce the modified version of the Dialogical Consultation Model.

CHAPTER 5:

AS THE RESEARCH JOURNEY CONTINUES:

> "Maybe it's like this, Max-you know how, when you are working on a long and ordered piece, all sorts of bright and lovely ideas and images intrude. They have no place in what you are writing, and so if you are young, you write them in a notebook for future use. And you never use them because they are sparkling and alive like coloured pebbles on a wave-washed ashore. It's impossible not to fill your pockets with them. But when you get home, they are dry and colourless. I'd like to pin down a few while they are wet".
>
> Steinbeck [1965, 17].

1.1. Introduction:

This chapter will commence the observation and critique of the Dialogical Consultation model. The first step of this journey was the conducting of a pilot study. I participated in the pilot study in order to observe the model directly. The observations and discussions in this chapter will arise from my engagement with the model[36].

1.2. How will I observe and analyse the pilot study:

The analysis process brings together two observational lenses. The gaze of each lens differs. The phenomenological lens observes how the participants experience the research theme and how they experience engaging with the consultation model. The Gadamarian lens observes the researchers experience. This observational activity promotes a study of the whole research picture, both the objective accounts and the subjective accounts. The observations will be sensitive to the task that is requested from the participants and attentive to, what I, as the researcher, brings to the project.

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[36] For the pilot study, one of my colleagues conducted the consultation. As discussed, the general aim of the model is to support a therapist when they experience a stuck phase in therapy. Thus, I brought into the consultation the stories of a client group that I had the opportunity to meet with and with whom I had become therapeutically stuck.

The observations that arise from the analysis activity will be filtered through the Action Research lens, the outcome of which will influence how the model evolves. This process will be revisited as I commence the analysis of the research consultations.

1.3. The pilot study: A retrospective observation:

When I initially started to develop the model, it was shaped by ideas from the dialogical approach to systemic practice, and influenced by a number of ideas from the cognitive sciences. The dialogical perspective brings with it two interrelated areas of interest: the reciprocal dimension of therapy and the internal dialogue concept. The internal dialogue concept prompted my interest in the cognitive sciences with particular interest towards how that field of study, firstly, describes the architecture of the internal dialogue, and, secondly, how it describes dialogical movement. In light of the aims of the model at that time, I judged that it would be constructive to incorporate ideas from the cognitive field into the model. I did not take into account the difference in perspective between the cognitive sciences and the dialogical lens.

1.4. The internal dialogue concept: A comparative description:

To take a step back, I will firstly look at how the dialogical perspective describes the internal-self and then introduce aspects of the cognitive sciences that I drew on to develop the model:

The dialogical perspective suggests that the architecture of the internal dialogue can be described as a combination of relatively autonomous decentered internal positions with distinctive voices and their encircling narrative web [see Hermans, 2008; Hermans, Rijks and Kempen, 1993]. Theorists have suggested that the voices act like characters in a story each striving for expression [Hermans, 2008], with some achieving dominance and others placed within a submissive or oppressed role [Hermans, 2004; Raggatt, 2000]. Each voice has its own life story and can emerge from a complex interaction between aspects of the self, as prompted by the *self-in-the-environment* and the *dialogical-other* [selected highlight] [see Hermans, 1999]. Furthermore, each life story has a built-in evaluative system that has the potential to evolve or remain unchanged [Stiles, 1999, 2007a]. This play of positions has been described as a natural process that leads towards the development of core positions with attached dominant narratives, and, in response, the development of marginalised or silenced narratives [Raggatt, 2000]. From this description, dialogical movement can be described as an oscillatory type movement between voices and their attachments with a move towards an increasingly advanced reflexive meta-position that is more encompassing of difference or a

move towards a restriction of expression [see Hermans 2004, 2008; Raggatt, 2000; Stiles, 1999, 2007a; Stiles et al, 2004]. This description, reflective of the ideas emerging in the systemic paradigm [Rober, 1999, 2005b], can shed light on how a therapist can experience either reflexive flexibility of reflexive stuckness.

However, my translation of this description was also influenced by ideas from the cognitive sciences. I began to visualize the internal dialogue as a tangible, autonomous landscape that was made up of structural components, of which, could be identified, characterised and manipulated. Moreover, I overlooked the point that external forces i.e. the self-in-environment and the dialogical-other, influence the composition and activity of the internal-self. As I now look back, and in light of my readings of the cognitive ideas, the model development was moving towards objectifying how the therapist processes the therapeutic encounter and the stuck phase.

Thus, the emerging aims of the consultation model at that stage of the project were:

1. To externalise the internal dialogue of the therapist with the aim to trace the internal positions and the emerging positions.
2. To explore position dominance and/or submission in response to a stuck phase and from that task to explicate the causative factors of the stuck phase.
3. On identification of the causative factor, to address and subsequently move towards a cognitive position of flexibility.

2.1. How did these aims translate to the pilot model format?

The dialogical model can be described as an experiment in motion. The pilot study was not necessarily a failure, but reflected my ideas at that phase of the project. The pilot evaluative framework as introduced in Chapter 3 illustrates my initial thinking. I have observed the pilot study with interest towards how to advance the model in light of the dialogical perspective. Four themes emerged. Each theme will be introduced with relevant verbatim attached.

Theme 1: The therapist's internal dialogue:

To open the critique of the pilot study, firstly, my thoughts at the time, were that the model demonstrated an overarching interest in the therapist's internal dialogue, as was expected, but in a manner that the isolated the therapist's voice from the client's voice:

Example 1-3:

Consultant: Line 509: “Are these voices contradictory?
Consultant: Line 516: At present, which voice is the strongest?
Consultant: Line 523-525: “How would you describe the position that these voices come from?”

However, there are instances when the model format steps beyond its overt interest in the therapist’s internal dialogue and creates a reflexive space where the therapist had the opportunity to reflect on their experiences, the client’s experiences and how they meet:

Example 4: Line 236-256:
Consultant: “Do you feel that there are many more stories to tell?”
Participant: “Yes, I think that there are a lot more stories to tell but I feel that there is reluctance within the session for me to ask these about these stories [pause]... I think there is a fear on my behalf around what stories might arise.
Consultant: “Why do you think there are more stories?”
Participant: “I get the sense that there is more stories because initially she was very cautious about her mother’s unwellness and her father’s history [pause]...now that she is that little bit more open and angry I think that maybe there is something that has been missed and that maybe this anger stems from this?”

This particular line of questions was initiated by my colleague in response to an earlier line of questions that came directly from the format. What is interesting about this set of questions is that they create a space to reflect and support the therapist to move into a systemic lens. What can I learn from this section? The style of question is paramount. However, more importantly, what perspective the question arise from is paramount. For the pilot study, I was influenced by the cognitive lens, a valuable lens, which helped me to understand the processes of the internal dialogue. However, there was a central component absent from my perspective i.e. the dialogical aspect of reflection, which encompasses an interest in the other, an interest in how you engage with the other and an interest in the shared reflexive space. A consultation model directed by this perspective would allow the stuck experience to unfold in a way that brings forward all voices. This reflection brings forth the need to revisit the model and amend.

Theme 2: An objective and deductive line of reasoning versus a dialogic-systemic reflexive lens:

In correlation with theme one, the pilot model format prompted an objective and deductive line of reasoning. In addition, it illustrated marginal interest in the client's experiences and stories shared:

Example 1: Line 188-189:

Consultant: "Initially in therapy with this client what dominant ideas did you have?

Example 2: Line 197-198:

Consultant: "What if any secondary ideas did you have?"

However, a number of the model questions through default prompted the therapist to envisage the client's voice as part of their own internal dialogue and by that process initiate a dialogic-systemic reflexive lens:

Example 3: Line 203-208:

Consultant: "What questions did you pose to yourself?"

Participant: "I did pose questions around the client's resilience and wondered where did she find the strength or resilience from?"

Example 4: Line 500-513:

Consultant: "Are you aware of any divergent internal voices within yourself?

Participant: "Yes there is a contradiction between what I should be doing and what I feel the client is ready for".

Family therapists envisage the therapeutic process from a systemic lens [see Rober, 1999]. This lens encourages the therapist to metaphorically stand in the shoes of the client, observe the shared story from the client's perspective, from their own perspective, and, observe how it reflects into the therapeutic dialogue. This resource can be seen in the examples provided. The model did not intentionally draw from this resource. Again, this idea will be addressed as the project proceeds.

Theme 3: Meaningful lines of inquiry:

The consultation dialogue missed a number of meaningful lines of inquiry that if picked up on would have illuminated the dialogic–other and the intersubjective space and potentially supported new ways of moving forward in the therapeutic process.

Example 1: Lines 29 – 58:

Consultant: "When do you think that you first noticed stuckness?"

Participant: "I would say that it is going as far back as October"

Consultant: "And how did you notice that you were moving into a stuck position?"

Participant: "It was not necessarily in the style of the conversation... that it was fragmented, but, it was more an experiencing of a stuck phase between us, awkwardness, like an emotional awkwardness, rather than the conversation becoming stuck. Yes, it had become repetitive but that didn't seem to matter [pause]...more an atmosphere of stuckness."

Consultant: "So do you feel that the client would have noticed that this was a stuck phase?"

Participant: "I think she did then I began to get a sense of anger emerging from her ...and this is something that I hadn't noticed before".

Consultant: "Apart from the anger was there anything else different about the experience as compared to a period in therapy when you were achieving movement?"

The question that arises from this theme is how effective and supportive is a structured consultation format? Does it offer the space to explore and reflect on emergent themes? What is the task of a consultation in light of this image? Moreover, where does a structured model fit with this description? This theme will be revisited as I move through the research consultations.

Theme 4: The experiencing-self of the therapist:

I participated in the pilot consultation. How did I experience the consultation process? With surprise, I found the consultation challenging in that the questions directly requests you to look closer at your experiencing-self. I found that, disclosure to one-self and the other [i.e. the consultant] becomes central to the consultation process. This process can be emotionally demanding and becomes more challenging when you are requested to share your reflections in a consultation process. During the course of the pilot interview, I found myself shifting between openness and non-disclosure:

Example 1: An openness lens:

Line 257-262:

Consultant: “Initially how would you describe your position towards the stuck phase?
Participant: “Emmh...I think a stuck phase is very easy to ignore and you step through your sessions in a routine and they get fairly repetitive and that in a funny way is quite comforting...”
Example 2: A non-disclosure lens:
Line: 587-595:
Consultant: “Does this feeling or the stories of any of the voices prompt you or evoke any other voices that you had forgotten about?”
Participant: “I don’t think so, does it evoke other clients or other stories that I have heard [Pause]...I don’t think so...is it evoking some inchoate voice I am not too sure?”

This poses a significant question. The model questions aim to gain insight into the internal-self of the therapist and to prompt communication between the multiple of internal positions and the multiple of selves [see Bakhtin, 1981]. What will this process achieve? It will map out the field of voices and by doing so will have the potential to promote multiplicity of thought. However, what remains unsaid up to this point is that it will shed light on the therapist’s field of experiencing-voices. Will there be a conscious move towards non-disclosure by the research participants? Moreover, how will this reflect on the effectiveness of the model? During the course of the pilot consultation, I found that I concealed my own experiencing-positions by diverting to systemic reflections and by the use of professional lexicon. This theme has arisen in systemic literature with the idea that although these reflections are constructive, they have the potential to guide observations, direct dialogue, and, subsequently overshadow the experiencing-reflections [see Rober, 2011; Rubinstien-Nabarro, 1994]. This question will be addressed as the project moves through the research consultations.

3.1. A revision of the researcher’s perspective:

To bring together my ideas as I complete the observation of the pilot study: What did I overlook as I put together the first draft? Firstly, the internal-self of the therapist was viewed as an isolated entity with limited attention towards the dialogical other i.e. the internalised client’s voice and the intersubjective space. By showing limited interest in the *self-in-the-environment* and the *internalised-other* aspect of the internal dialogue, it produced a consultation that did not build on the reciprocal dimension of understanding and therefore the intersubjective space remained unchanged [selected highlight]. In light of this, the

consultation may have assisted the therapist to view their reflections and identify their own roadblocks. Thus, one aspect of stuckness may have been addressed. However, the dialogical therapist is interested in the internal-self, not as a standalone-self, but as a self that is situated within a generative dialogue where otherness-is-central. This aspect of reflection was not fully addressed.

Thus, how do I move forward with the model construction?

In response to the pilot study, the aims of the model are evolving with a move towards a consultation that prompts the therapist to draw on their reflections and self-experiences, as they participate in the therapeutic activity, as was the initial aim. Also, to add strength to the voice of the client group, its position in the internal dialogue of the therapist and its position within the therapeutic dialogue. This activity directs attention to the intersubjective space[37].

Therefore, with that thought, at this stage of the model development the idea would be to refocus my perspective, and subsequently, revisit the model questions and look at moving towards a more phenomenological/dialogical style consultation.

Secondly, and in response to my concern with the emergence of deductive reasoning patterns as prompted by the pilot format, the consultation model needs to work towards establishing a consultation process that by nature is an ongoing process that does not drive towards closure [see Sheehan, 1999[38]]. The idea of cognitive horizons [Gadamer, 1990/1960] appears straight forward, but in practice, I believe, it remains difficult to achieve[39]. The pilot interview did open some reflexive ideas but in general, the consultation moved towards deductive reasoning patterns. How do I generate and sustain a hermeneutic/dialogical reasoning style? The pilot format was examined with attention directed towards how the questions were formed. To start this revision I looked at one of the opening questions:

Example 1: Line 1-3:

Consultant: "I would like you to describe the stuck encounter that you are experiencing?"

With attention towards Gadamarian/dialogical ideas, the question was modified:

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[37]The ideas of Binswanger [1947], as read by Frie [2010], also supported this shift in perspective. Binswanger talked about the totality of the lived experience with the idea of bringing forward the different observations of the phenomena under investigation, not glimpsing it as an isolated incident but rather as it presents itself against the background of an "I". On reflection of Binswanger`s ideas, I understood that my observational lens needed to broaden and to take in all perspectives.

[38] See Sheehan [1999] in reference to the ideas of Bakhtin [1981, 1984, 1986].

[39]Many theorists cite that human instinct drives towards closure [see Heidegger, 1962 /1927].

Consultant: “Let us look at the therapeutic encounter with the client group that you have identified...when you sit with this family what do you observe”.

This form of question creates multiple lines of inquiry. Therefore, promotes multiplicity of thought rather than deductive reasoning. This subject will be part of the Action Research observation of each consultation with attention directed towards the question style. The outcome will be fed back into the construction of the model.

4.1. A synopsis:

The pilot study has brought forth many questions. From a retrospective position, it is interesting to note that the initial aim of the model was to direct attention solely to the therapist’s thoughts in response to a stuck phase. The internalized-other and the intersubjective space, key aspects of the dialogical approach to systemic practice, were overlooked. I revised my perspective and subsequently commenced a revision of the aims and framework of the model.

In light of the evolving perspective, the following chapter will look at the five research consultations one-by-one and track how they were influenced by the changing perspective. An Action Research lens will overarch this discussion. Each consultation analysis will commence with an observation of how therapists described stuckness and how this description is influenced by the consultation model.

CHAPTER 6:

THE PROCESS OF ANALYSIS:

I have heard many years of telling,
And many years should see some change.
The ball I threw while playing in the park
Has not yet reached the ground.
Thomas [2000/1933, 33].

1.1. Introduction:

First, this chapter will re-visit the process of analysis.

The chapter will then proceed to put forward the evolving reflections of both the researcher and the participants as they progress through the consultations and how this collaboration influenced the understanding of stuckness and the development of the consultation format.

1.2. The process of analysis:

As noted, the analysis framework brought together two observational lenses. The analysis is a lengthy process and requires a form of stepping into and out of the different consultations, the different observational lenses and the different voices i.e. the researchers, the participants, the literature, and, the collaborative voice. As discussed, I will share the analysis development as if I am telling a story. The story will commence at the first consultation and proceed through each consultation as they occurred. As the story unfolds the different narrators will take centre stage bringing with them their unique perspectives, sometimes sharing new insights, sometimes at variance with the other characters, but at all times moving towards a community of voice that embraces all ideas[40].

[40]The story telling process is a moving observational frame that incorporates the actor's perspectives as they appear at that time and as they modify in response to the changing story. As you are aware my perspective changed as the research proceeded. The opening consultations were influenced by my initial perspective. Please take that in account when reading through this story. The question that arises is: Why did I approach the analysis in this from? In response, I felt that in order to fully illustrate my changing perspective as influenced by the participant's ideas and engagement with the model, I stepped through each consultation one by one. I appreciate your patience.

In order to provide some direction, each consultation analysis will follow the attached observational and reflexive steps. In addition, in order to track the emergent and super ordinate themes as observed through the phenomenological lens refer to Appendices 6 and 7.

Table 4: Observation and analysis trajectory:

Observational and reflexive steps:	*Theoretical or research lens:*
A pre consultation observation of the model and the researcher's perspective:	As guided by the Gadamarian lens. Outcome will be directed through the Action Research lens.
Consultation observation: Analysis of participant's reflections on the projects theme, stuckness; their engagement with the model; the participant's observations with reference towards the use of position statements; and, observation of emergent themes.	Interpretative Phenomenological Analysis to inform [see Appendices 6 and 7].
Post consultation collaborative dialogue with participant.	Interpretative Phenomenological Analysis and Action Research to inform.
Post consultation observations as conducted by researcher.	As guided by the Gadamarian lens. Outcome will be directed through the Action Research lens.

With that, the story continues...

2.1. Pre Consultation 1 observations as directed by the Gadamarian lens and filtered through the Action Research lens:

Amendments from the pilot consultation[41]:

The observations of the pilot consultation put forward a number of criticisms. It raised questions regarding the initial theoretical base with ideas put forward that would support a

[41] See Appendices 8 and 9 to track ongoing changes to model format.

more dialogical perspective. The task is to meet with the research participants, put the model into practice and, from that collaborative activity, revisit the model format and amend in light of the new ideas.

Post pilot study and pre consultation one there was a shift in perspective beginning to emerge with the idea of Gadamarian hermeneutics, dialogue and phenomenology coming forward as a more fitting lens for the model. However, as I revisit the opening consultation, I am surprised how my perspective was changing but I was not translating this change to the model format. For consultation one, I removed the family lens questions, as I felt at that time, that it complicated the consultation process. Yes, to observe the family perspective is a natural systemic activity. However, the task of the model at that stage was to externalise the therapist's internal dialogue and support cognitive fluidity. It is interesting to revisit the consultation one amendment. The amendment reflected the original tasks of the model. It focused solely on the therapist somewhat isolated from the systemic encounter. It reflected my initial reading of the cognitive perspective.

Interestingly, at the same time, my ideas of the Position Statement were changing. At first, I described the initial position statement as a component of the analysis process. I reported that it would offer a baseline understanding of the stuck phase with the follow on position statements shedding light on cognitive movement. Thus, its task was to observe the effectiveness of the model. This description again reflected my reading of the cognitive lens. Interestingly, at consultation one, I was beginning to view the position statement task as a reflexive activity that would enable the participant to track any changes in how they observed the therapeutic process and from that activity support the development of a meta-observational position. Although, not a significant change in the model format, it illustrates my changing perspective. I was beginning to view the participants as active, reflexive participating agents in a therapeutic system and not as a cognitive mechanism that could be interpreted and directed.

With regret, I was unable to transcribe consultation one as the recording was of a very poor quality. However, again from a retrospective position, I now believe that this extra space allowed me, as the researcher, the time to revisit my perspective, sit with it for a while, and contemplate how it influenced the various aspects of the project.

3.1. Consultation 2: Teresa:

Teresa engaged in consultation 2. For this meeting I struggled with how to position myself within the consultation. Do I adopt a consultant role or a researcher role? Both different tasks. This theme will be revisited as the analysis proceeds.

The analysis will follow the developed observational/analysis format:

3.2. Pre consultation researcher observations as guided by Gadamarian hermeneutics:

As I moved towards meeting with Teresa, I became very doubtful of the internal dialogue approach to consultation and the structured approach of the model. I wondered how it would translate to practice. As I attempted to recruit participants, each person spoke of their dislike of structure and questioned the models ability to promote reflexive thinking. The difficulty in recruiting family therapists did at the time influence my belief in the model and the project. At the same time, and by chance, I came upon an interesting discussion on the theory of language [Everett, 2012]. Although it appears to be somewhat out of place in this current discussion, it did provoke questions regarding the model, my use of the internal dialogue concept and the structured design. To look at the question that arose: Languages can be described as a tool of a culture embedded in the uniqueness of the environment in which it is formed. The argument that Everett [2012] puts forward, is, that the translation of a language is a reductive undertaking that through its course loses the uniqueness of meaning [in anthropological terms]. To bring this thought to the model: Is it possible to translate the complexity of a family session to a consultation? Is the uniqueness of observation and meaning development lost in translation? If so, is the model of value or is it simply an activity that superficially addresses the task in question? Together, these questions ask is a structured model based on the internal dialogue concept useful. Will the research consultations answer that question?

I approached consultation two with these questions. The follow on discussions will study the consultation with these questions leading the analysis.

3.3. Interpretative Phenomenological Analysis:

To start the observation, I will look at how Teresa, described stuckness, and then, track how the description evolved in response to the consultation:
At first, Teresa described stuckness as a conversational roadblock:

Example 1: Line 1-18:

Consultant: “I would like you to describe to me how you experience a phase in therapy when you are stuck”.

Teresa: “I suppose I have this thought that stuck means, like when I am stuck in a session, you know there is a gap, a silence, and I don’t know what causes it, maybe it is that the family come with something that I am not expecting, or that the family don’t answer a question or cut short or sometimes I get in a session where I don’t know where to go with the information”.

Example 2: Line 84-93:

Consultant: “I am just thinking what do you notice or what thoughts do you have when you enter one of these silences?”

Teresa: “In myself there is a lot going on in my own head there is different ideas and I am wondering how I can ask these questions of the ideas in my head to move it along.....I notice stuckness when I am formulating a question”.

At first, it appears that the stuckness is triggered by the therapist’s hesitation in formulating a question. However, as we continued and moved into the experiencing-domain, Teresa introduced two factors that supported the hesitation.

Firstly, Teresa observed the stories that the identified family brought to therapy and explored how these stories did not connect with her own ideas as triggered by her early life experiences and current way of observing family values:

Example 3: Line 452-469:

Teresa: “It certainly would be bringing me into a totally new territory, it is taking me out of my comfort zone, and I now know what is triggering this feeling ...it is my own strong values on what family is all about, and what I would like to pass on to my children and what I would like them to pass on to their children”.

Teresa shared that this disconnection was prompting the emergence of “maternal instincts” and a sense of “protectiveness” towards the identified client [Teresa, 364]. The emergence of these emotions was prompting her to look at changing the family rather than supporting them to explore their ways of understanding family life: “I was on a bit of a pilgrimage...to prove

to them that parenting does impact on the family and maybe open up their eyes to or connect to what is happening" [Teresa, 268].

Secondly, Teresa explored how families participate in the therapeutic process, and reflected on the idea of shared and unshared stories and referred to how "unspoken family rules may stop certain themes been discussed" [Teresa, 216-217]:

Example 4: Line 179-191:

Teresa: "Stuckness is like when I pose questions like for example violence and aggression like when I name things as I see them that can cause stuckness [pause]...if my questions grate against their thinking then the roadblock arises....and if there are teenagers they take their cues from the parents".

Thus, from this description, stuckness can be described as a co-evolved, co-created and shared, responsive[42] process that activates a technical or conversational block outcome. In this description it is triggered by the therapist's unease with the unshared stories and hence a difficulty with formulating a question, and, in correlation, the family's reluctance to share and explore these stories. From this tension, a conversational roadblock arises. This description puts forward a multilayered, multi-positioned explanation of therapist stuckness, a description that fits with the dialogical perspective.

This explanation suggests that to address stuckness through a consultation requires a reflexive process that prompts the exploration of the multiple of different voices, both internal and external, in a manner that promotes a curious inquiry frame that invites the therapist to engage with their dialogic-self, their self-as-part of the therapeutic process and the dialogic/internalized-other [i.e. the internalized voice of the client group]. This process supports the therapist to connect with the family in a creative manner and thus support new ways of observing the encounter with the potential creation of endless shifts in observations, responsiveness and ways to proceed [see Anderson, 2007a; Rober, 1999, 2008c, 2010]. This suggested consultation process also fits with the dialogical perspective.

3.4. The participating therapist's engagement with the model:

[42] The term responsive within this description refers to the influence of the therapist's and the client-group's historical-self, emergent-self and intersubjective-self within the therapeutic environment and how they connect and participate.

The position statements may shed some light on how the participant engaged with the model. Teresa at the start of the consultation spoke of a sense of not connecting with the family and tentatively introduced the idea that her own dialogic-self restricted this connection with Position Statement[43] 1 identifying two interrelated themes: How to be "in tune with the family" while at the same time "valuing my own ideas". As we moved through the consultation, Teresa continued to reflect on her ideas and how they were different from the family with P.S.2. identifying: "Difference" as a trigger to stuckness. With this theme, Teresa looked at different perspectives, and how different perspectives prompt different ideas about what is important to a family. This shift in observation placed Teresa in the shoes of the client group and brought forward the stories that were important to the family. This empathic interest in the client group introduced alternative ideas of how to continue in the therapeutic meetings with the P.S. 3. citing "Possibility...and hope". Teresa's closing reflections looked at how she could next meet with the family and within that meeting request the family to explore how they observe their stories with P.S. 4. citing that she would: "Approach the families with a different mind frame...focus more about their thinking".

How can this description, as shared by the therapist, be understood in the context of this research? Firstly, the model questions supported the therapist to identify all aspects of their self that emerged in response to the therapeutic meeting. Secondly, this activity supported the therapist to reflect on the stuck experience in a manner that prompted a move beyond the initial description with a move towards a meta-observational reflexive position that brought into focus their observations, the stories of the client group, how they connect with the therapist and how they are positioned within the therapeutic dialogue[44]. This process prompted a multiplicity of thought and supported different ways of moving forward in the therapeutic trajectory.

3.5. The post consultation collaborative dialogue:

At the post consultation meeting, and in light of my earlier thoughts, Teresa highlighted how I, the researcher, positioned myself in the consultation. Teresa put forward the observation

[43] The term Position Statement will be cited as P.S. for the remainder of the thesis.

[44] I have noticed that the development of the meta-observational position enables the participants to view more clearly all reflections and from that reflective position not get caught up in the dominant reflections. This process assists a move towards a process of building bridges between the reflections, creating a community of linked ideas, hunches etc. rather than the reflexive activity and subsequent therapeutic dialogue dominated by a singular isolated reflection. This is not a new observation [see Stiles, 1990; Rober, 2005a].

that at times we interacted like supportive colleagues. Moreover, at times, our relationship reflected a researcher /participant dyad. We observed that this variation in positioning produced a shift between a collaborative and a deductive dialogue. From our discussion, I posed the question: What position should I adopt? The literature was revisited. The ideas of Beebe and Lachmann [2003] came to my attention. They discussed the idea of an interactive regulation continuum [2003, 400]. Although not directly linked to research, this idea looks at the benefit of moving between the various interactive modes in order to accommodate dialogue. From this reading, I felt that a flexible position[45] may be advantageous and reflected the Action Research lens. I shared this idea with Teresa. In response, she noted that reflections as developed through a consultation process evolve in an ebb and flow manner. This reflexive activity requires a build-up of trust with the consultant. This buildup of trust can be supported by the consultant adopting a measured interactive form i.e. not overly engaged and at the same time not too distant. From this collaboration, it appears that the midrange interactive positions may support the effectiveness of the consultations and the research project. This idea will be brought forward to the remainder of the consultations.

3.6. Post consultations observations as guided by Gadamarian hermeneutics and filtered through the Action Research lens.

Emergent themes:

1. A dialogic exploration:

The critique of the pilot study adjusted my perspective. I began to look towards the need to generate a consultation format that was more dialogic. In response, during the course of this consultation I stepped outside of the model format. The model questions up to this point remained unchanged. They posed a direct question and requested a specific answer. When I did step out of the format and posed responsive questions, it generated an interest in the internalised-other and the intersubjective space. By stepping back into the format, it reduced the development of meaningful explorations:

Example 1: line 383-394:

Consultant: "I am picking up that you are uncomfortable with the unshared stories?"

[45] By this term I indicate the ability to move between a supportive collaborative position to an objective position with the view that this altering of position supports the consultation and the conducting of the project.

Teresa: "I am more uncomfortable with the negative feelings...and how I see Sally and her family..."

Consultant: "This appears to be raising emotions with you ...and then you are wondering how to move forward..."

Teresa: "yes" [long pause].

Consultant: "What would your professional-self say about the stuck phase and what are these ideas telling you to look at?"

However, in contradiction, although the structured and cognitive framed questions do not fit with the emerging perspective, I judge that they do have a number of roles that support the overall consultation[46]. Firstly, they offer a consultation scaffold. This scaffold ensures that all features of the internal dialogue are brought to attention. Secondly, structure provides continuation. I believe consultations can become stuck with dominant ideas directing the activity. With dominant ideas, silent or subsumed reflections can be left unsaid. Thirdly, structure brings with it a level of support for the therapist. To qualify that statement: Some lines of reflection generate discomfort and require time to process. Therapists may not always be in the position to explore all emergent reflections. A structured approach supports a therapist to tentatively look at themes with the opportunity to move forward and revisit emergent sensitive themes at a later stage. Thus, structure brings with it some advantages. However, returning to my earlier criticisms, to create a reflexive activity that brings forth the internalised-other and the dialogic-self, the model questions must reflect a phenomenological /dialogical lens. Therefore, the task is to revisit the model and further include phenomenological /dialogical framed reflexive questions and balance with the questions that are directed at explicating all reflections.

2. The Position Statement:

With the conclusion of Consultation 2, I noticed that up to this point the theoretical and linked perspective shift was only evident in my thinking. I did not translate the shift to the model with the exception of the opening question as highlighted in the pilot interview. With this thought, I noticed that the wording of the P.S. was out of place with the evolving perspective. I thought over this critique and looked at the idea of formulating a P.S. question that would promote a dialogical and hermeneutic perspective. With that thought, the P.S. was

[46] These ideas reflect Teresa's consultation.

amended. Thus, for the follow on consultations the task of the first P.S. is to create a meta-observational platform with the remaining P.S. supporting further development:

Position Statement 1:

P.S. 1: "How can you now describe how you understand or observe the stuck phase?"

The follow on P.S. will take on the new format:

Position Statement 2-4:

P.S. 2-4: "If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation to the stuck experience and the client group that you introduced?"

3.7. Closing thoughts on Consultation 2:

Hence, can a move between a dialogical and a cognitive perspective support a therapist to process stuckness? Firstly, I will look at what was achieved in Consultation 2. For this consultation, the model provided a scaffold that ensured all aspects of the internal dialogue were expressed. In continuation, the model prompted to some extent, a Gadamarian approach to the reflexive activity, in that there was a movement between the historical-self, the here-and-now-experiencing-self and the systemic/professional-self [see Gadamer, 1990/1960]. In addition, the position statements supported the development of a meta-observational position. However, all aspects of the internal dialogue were not fully developed. The internalised-other and the dialogical-self, were not openly introduced by the model questions[47]. This reflection leads into consultation 3 with attention towards further developing a dialogic form of reflection.

4.1. Consultation 3: Michael:

To revisit the write up process: To this point, I have attempted to draw on the multiple of narrators and perspectives. However, I feel that the story so far shows no real sense of curiosity regarding how the participant's experience the model. This line of inquiry would

[47] Interestingly, Teresa illustrated how her systemic mode of reflecting brought forward these positions. Questions that prompted these positions: "Are any of these hunches or experiences familiar?", and, "Are any of these ideas, feelings or hunches unfamiliar?"

shed light on how it may fit with the wider systemic community. This observation will be included at the completion of the consultation 3 analysis.

The following discussion will again move between the different lenses. Thus, it will commence with the pre consultation 3 notes:

4.2. Pre consultation observations as influenced by Gadamarian and Action Research lens:

As I move towards consultation 3, I continue to wonder can the model revise the way the therapist observes the client group and the stories they share or is it that the model produces no change.

In light of the above question, I revisited consultation two. As I reflect over the participant's consultation, I noticed that by highlighting the dominant reflections at the start of the consultation i.e. the difficulty with formulating a therapeutic question in response to a feeling of "uncomfortableness" with the client group stories [Teresa: 10], brought into focus the subsumed voices, which comprised of the here-and-now experiencing-voices, which in turn triggered the historical experiencing reflections : "Maternal feelings arose" [Teresa: 364], and "what I value with my children" [Teresa: 369]. This reflexive activity shifted the therapist's reflexive lens and prompted a questioning of her dominant ideas. Did it produce a change in how she observed and engaged with the client group? The therapist's values remained unchanged. Nevertheless, the consultation prompted her to step out of the dominant position and observe the emergent constellation of reflections, a process that generated empathic reflections and thus a strengthening of the client group's position in the reflexive dialogue [see Byrne and McCarthy, 1998; Flaskas, 2010]. It produced a shifting of lens and this shift introduced a reflexive change. Thus, for this therapist the model produced a shift in observation. From that proposition, does the model prompt a short-term change that comes forth in the consultation and the subsequent family meeting? Teresa did share "I know that it is my strong values on what a family is about" [Teresa: 465]. Or, a lasting modification to the therapist's observational patterns? This question lies outside of this project but raises interesting questions regarding consultation processes.

With these ideas, I moved towards consultation 3.

Two modifications were introduced. First, as described, the P.S. wording was altered in order to support the development of a meta- observational position. Second, to correspond with the changing ideas the aims of the model were re-addressed with aim 4 added:

Aim 4: The development of a meta-observational position, which enables the therapist to view all reflections and their relationships in a more receptive environment, with the aim to work towards a community of linked reflections, and observations that will create a multiplicity of thought and a flexible perspective to family or client group stories and dynamics.

4.3. Interpretative Phenomenological Analysis:

The opening phenomenological framed discussion will firstly explore how Michael describes stuckness and then move into themes that emerged during the course of this consultation:

Stuckness as a dialogic phenomenon:

Michael's opening description described stuckness as an isolated phenomenon:

Line 9-16: "Sometimes I panic and think what am I going to do now and there are times when I think where is this taking me";

And,

Line 19-26: "Is it that I am stuck, the families are stuck…or is a place where they feel uncomfortable?"

In response to this reflection, I requested Michael to look at when he experiences stuckness: His response was:

Line 35-42: "I might have let's say hypothesized about the family before they come in and thinking about a particular line of inquiry and then I meet them and something else comes up" .

From this reflection, Michael moves on to say that stuckness is uncomfortable in that he feels pressurized to do something and that there is an expectation [from the client group] for something to happen: "There is an outcome or the conversation will come to a point where the people feel that something is happening" [70-80]. The opening P.S. reflects Michael's idea: "Been stuck can be poor...challenges me to refocus on avoiding getting stuck". This opening description suggests a disconnection between the therapist and client group, and positions the professional expectations as the key catalyst to how the therapeutic journey proceeds. As the consultation proceeded and moved into the experiencing-domain of inquiry, Michael spoke of the emergence of feelings as he engages with the client group and as he revisits their story through the consultation process: "feelings of empathy" [149], ideas of "feeling trapped" [151], "I want to place myself in a position where I am helpful to her" [284-

287], ideas of been able to "contain this difficulty" [382-383]. In continuation, Michael shared that he felt that the emotions "invites me to be a bit more attentive to her" 169-171], and these emergent emotions support him to find ways to connect with the client group:

Example 1: Line 175-186:
Consultant/Researcher: "You mentioned about empathy where does that arise from and how does that influence therapy?"
Michael: "Well yes, it helps me find questions or conversations that are attending to her story of care".

The introduction of the emergent self-experiences supported Michael to explore how he positions himself in the therapeutic dialogue. At the close of the consultation, Michael further reflected on his experiences and questioned his opening ideas regarding the use of a pre-session hypothesis: "In my own head I am already thinking ahead and had worked something out" [post consultation: 313]. Michael then met with the client group. On reflection of this meeting Michael shared that he approached this session with a "not knowing position" [post consultation: 384], "I was listening differently, I was listening more attentively" [post consultation: 398-400]. He observed that he "stepped deeper into her story" [post consultation: 485-486]. The closing position statement reflected an alternative way of meeting with the client group: "The importance of the inner/outer conversation, and, the importance of reflecting on the not asked".
Thus, the initial description of stuckness and the subsequent engagement in the consultation model supported Michael to observe how he had moved into a stuck episode. This process prompted him to look at how he connects with the client group and how he attends to the shared stories. This process supported Michael to observe stuckness as an episode in therapy that is influenced by a multiple of factors that includes the stories shared by the client and, how he, as the therapists listens, connects and responds to these stories. Thus, the consultation process promotes a wider observation of stuckness. This wider observation, similar to consultation 2, promotes a multiplicity of reflections and thus the potential for therapeutic movement. This description identifies stuckness as a dialogic phenomenon

Emergent themes:

1. The Consultation process as a dialogical storytelling activity:

Michael's consultation tells a story of "great sadness and loss" [548]. It presents as an ebb and flow of reflections that fit together to create a story. Michael presented a cast of characters. They are given identities that illustrate frailties, contradictions and aspirations. He introduces a variety of complex narratives. How do we read this form of consultation? As an intimate portrait of a client group and how they are observed by the therapist? Or, as a story of a client group and a therapist's encounter, a dialogic storytelling process that moves between the real time, historical time and experiences in a way that allows all to be heard? If so, this form of consultation could be described as a dialogic story telling process that has its roots in dialogue and hermeneutics.
Nonetheless, what brings this form of storytelling together?

Moreover, is this form of consultation beneficial?

To answer the first question, and on reflection of Teresa's and Michael consultation, both consultations supported the therapist to explore their experiencing reflections and to link these experiences with the client group e.g. Teresa reflected on the family stories and shared that they triggered a sense of rescuing and protectiveness and brought to the fore "what I value with my children" [Teresa: 369]. This connection triggered the emergence of empathic responses to the client group and from that reflexive activity supported new ways of proceeding in a way that connects with the client group: Teresa spoke of her next meeting with the client group and shared that she would work towards "been in tune with the family" [Teresa: 433]. Similarly, Michael spoke of the consultation as a process that brought to the fore experiences of empathy, protectiveness that "invites me to be a bit more attentive" to the client group [Michael: Post consultation: 169-171]. Thus, at this phase of the research project, the therapist's observation of their experiencing-self within the consultation process supports the development of a dialogical storytelling process.

In response to question two, is this form of consultation beneficial? Storytelling is a natural phenomenon in systemic therapy. It provides a way to observe all the aspects of a therapeutic encounter, the qualitative differences [see Sheehan, 2004] and the shared space [Rober, 1999; 2005b, 2010]. Thus, it is beneficial in that it promotes multiplicity of reflections.

2. <u>Non-disclosure strategies:</u>

Both Teresa and Michael have shared aspects of their experiencing-self and how this reflexive activity supported the therapeutic dialogue with Teresa noting, "How do I make

questions out of what I am asking myself?" [51-53]. However, the experiencing-domain questions appeared to challenge the participants. Michael shared that therapy is "not about us [the therapist] but about their story [the client group]" [post consultation review: 321]. Michael continued in this line of reflection noting that:

Michael: Post consultation: 358-369:
"Is it that there are lot of similarities about my own life and you know that therapists are not suppose to do that and I felt that I was short changing this person in front of me in that the person is there but I am thinking about myself ".

Looking at consultations 2 and 3, both participants do move between reflexive disclosure and non-disclosure with a number of non-disclosure mechanisms employed. Both Michael and Teresa brought into their consultations professional lexicon and broad systemic ideas to divert from experiencing reflections. Yes, the professional and systemic ideas are an essential part of the reflexive process and do support the therapist to observe the therapeutic encounter in a comprehensive manner. However, for consultation 2 and 3, I do believe these reflections were employed to divert from the experiencing domain.

Example 1: Line 300-313:
Consultant: "But where do the ideas of protectiveness come from?
Michael: "Like I have been influenced by narrative ideas and dialogical ideas, well I suppose lots of ideas are all grounded in the notion of care and also respect for people".

Reflective of Rober et al [2008a] and Masons [2010] observations, is therapeutic observation of the therapist-self, considered unimportant? Moreover, in response, is this section challenging the participants? The participants do shift between disclosure and non-disclosure. What is this indicating? It highlights the need to re-examine the experiencing questions and ask should they be included and if included should they be more tentative. In light of both consultations, I judge that their inclusion is necessary. However, I believe that a more transparent introduction would be helpful.

3. The internal dialogue: A complex web of interconnections:

Michael introduced the idea of a multiplicity of internal reflections supporting his engagement with this family. Michael referred towards his moral voice, the life-experiencing

voice, a voice of respect, a cultural and faith voice and a voice of justice [349-360]. Michael also spoke of his empathic reflections triggered by similarities with his own personal story: "I feel great empathy for her" [150], and, "there is a connection between me and her and how I see her situation" [195-199]. As the consultation proceeded, Michael reflected over the multiple of reflections that arose and spoke of how "they complement each other" [364-365] and support him to connect with the client group.

This description raises two ideas. First, can we describe the internal dialogue of the therapist as a complex web of reflexive interconnections that compliment, challenge and support each other.

Second, if this is the case, this description broadens the description of the meta-observational position. To this point, this position has been described as a cognitive space where all reflections are observed and seen as worthy. Michael's description introduces another dimension to this position. As noted, the meta-observational position brings forth all reflections and in line with Michaels reflections, supports therapist's observation-of-self and hence a move towards the therapeutic-use-of-self in the therapeutic environment.

4.4. Post consultation 3 observations: Therapist and researcher dialogue:

During the course of the consultation, Michael looked at how professional expectations push him to direct the therapeutic process and thus not wholly connect with the client group.

I met with Michael after he engaged with the client post consultation. He spoke of a different form of engagement. He noted that "actually you know I found myself not saying a whole lot, but she just told me her story [post consultation: 35-37], and that it was not about "me trying to direct the conversation with an expectation for a certain response" [209-212]. With this revised way of engaging, Michael shared that he felt liberated [post consultation: 110]. Yet, he reflected on "the not knowing" way of engagement and shared that "somehow this is challenging me ...I suppose it is an invitation and a challenge to step back and to really listen" [285-290] and to "allow the conversation to happen" [406-407].

Together we spoke about the model and wondered how it facilitated this different type of engagement [494-507]. Michael revisited the consultation process and how it brought forth his own story, and, how that reflexive activity supported his connection with the client. Michael's engagement with the client thus became a human activity removed from professional expectations: "and just to sit with the terrible sadness and loneliness" [post consultation: 417-418].

4.5. Post consultation 3 observations: Gadamarian lens as filtered through Action Research:

> "I was then living a quite harmonious poetic life. Never thinking out of my depth. Always harmonious, narrow, calm. Taking small interest in people but most ardently moved by the more minute kinds of beauty…."
> Yeats [1984/1888]. As cited in The Irish Times [2012, 32].

As I reflect on my interaction with the participants 2 and 3, and on the reflections shared by Teresa and Michael at the close of the post consultation meeting, I became aware that my attention was solely focused on how the model was unfolding and whether it was accomplishing the task it was designed to do. I took small interest in the research participants, in the stories they were sharing and how that sharing was touching them as a therapist and as an individual. This brings forward two thoughts.

First, is the model ignoring the personal aspect of the consultation process? To look closer at this question I will draw from consultation 3. Michael shared a story of sadness and loss. I placed attention on how Michael observed this story from the family's perspective. I did not ask Michael what it was like for him to hear these stories. Is this the experiencing aspect of therapy that I strive to uncover through this model? Do I introduce a question that requests the therapist to explore how they hear the family stories? If asked, would it add depth to the experiencing-self exploration?

Second, and in the spirit of Gadamer [1990/1986] and the concept of horizons, what if I looked at questions that remain with the therapist long after, and, thereby rather than extinguishes further reflections continually prompts newness in reflection or continuously prompts a reach for new horizons? What questions reach beyond the model, the research programme or reach beyond a consultation? What questions can I pose that remain with the therapist and prompt continual renewal? Michael noted that he liked question 14, draft 3 i.e. "What questions have you not asked so far?" When I reflect on this question, I feel that it opens a multiple of ideas. It lends itself to the horizon concept in that it prompts continuous reflections that can alter and ignite differences in observations and reflections. Will the model benefit from more questions like this?

In response to both these thoughts, I will introduce this question:

<u>Model format prepared for consultation 4 [Draft 5]: Phase 1, Question 2:</u>

Consultant: “What is it like to sit with this family and hear their stories?”

4.6. Action Research lens in response to evolving reflections: Modifications to the model format [Post Consultation 3 Format: draft four]:

1. The term theoretical-self is to be replaced by the term “systemic ideas”. I judge that this amendment will support the therapists to focus on their systemic ideas rather than broad theoretical ideas.
2. I have revisited the pilot format and found this question: “Have you become aware of a voice emerging from the background?” I am unsure why I deleted it. It requests the participant to explore alternate reflections. In light of the evolving task of the model [i.e. to support the development of a reflexive story that welcomes all reflections with the aim to create new horizons], it will be reintroduced with the word *voice* replaced with the word *reflection* [selected highlight].

These amendments lead us to consultation 4:

5.1. Consultation 4: Kathleen:

Kathleen engaged in consultation 4. This consultation brought forward powerful self-experiencing reflections, which generally in a consultation requires time to process. Regretfully, time was not available as the consultation was conducted during Kathleen’s lunch break. Furthermore, my attention was divided. My thoughts were on the research task. I was focused on how the model was working. When Kathleen brought forward the powerful reflections, it took me some time to acknowledge them.

The question that arises is: Is a consultation exploratory activity suitable for a research project where the researcher’s interest is divided between the research task and the consultation process? I have addressed this aspect in the ethical section and suggested a number of strategies including a pre and post consultation reflexive space for the participants. Is that sufficient support? This question will be posed at the close of this consultation analysis.

The analysis of this consultation will follow:

5.2. Pre Consultation 4 reflections: Gadamarian reflections as filtered through Action Research lens:

This is a revisiting of the model prior to consultation 4. This revisiting has been prompted by my earlier reflections on what it is I am trying to achieve with this model. Also, [and I feel appropriately timed], Kathleen reports that she has limited time. We have 40 minutes to complete the consultation. This factor will prompt me to lay aside my prejudice and modify the model. In response, I will overview the P.S.

The position statement has evolved. As noted, the wording has altered in line with attempting to prompt a more phenomenological/hermeneutic mode of reflecting. Its task has altered. At consultation 1, it was seen as a tool to measure cognitive movement. That task illustrated my thinking at that time. It was driven by a cognitive and research orientation lens. Consultation 3 illustrated a move in task. The task of the P.S. moved towards helping to enhance the meta-observational position and from that process encourage deeper reflection and thus multiplicity of thought. With my thoughts now, I would hope that it prompts a bringing together of all reflections, with an emphasis towards including the therapists self-experiencing observations and reflections.

In light of the time allocated to this consultation and the repetitive nature of the P.S. I will limit the P.S. to twice over the course of the model, rather than four times. This amendment also reflects the participant views. The participants noted that the earlier drafts of the model were intensive and required substantial reflection. To my current understanding, concentrated reflection may not always produce therapeutic insight.

The overall Consultation Format draft 5a has been amended with a move towards reducing the length of the interview [see Appendix 8: Consultation format draft 5b].

5.3. Interpretative Phenomenological Analysis:

This discussion will open with how Kathleen observes therapist stuckness. It will then introduce and explore the emergent themes:

<u>Stuckness as a dialogical phenomenon:</u>

Kathleen's opening reflections on her encounter with the identified client group described how she understood stuckness. Kathleen shared that she felt that the client group found that systemic conversations were challenging and in response were unable to connect with her way of engaging: "The idea of systemic can be challenging for some people" [53-54]. In response to the family's difficulty with systemic conversations, Kathleen found it difficult to connect with the client group: "How to join with them and hear their stories and...Just not knowing where to go with it" [11-13]. This description reflective of consultation 2 and 3,

describes stuckness as a disconnection between the therapist and client group. It suggests a conversational hurdle. As the consultation progressed and moved through the exploration of the various domains of inquiry, Kathleen's description of the therapeutic encounter broadened with the multiple of perspectives brought forward. Thus, as the consultation progressed the description moved towards a dialogic observation, which brought into focus:

How the client group [as introduced by Kathleen] observes their story and what their expectations are.

How the therapist hears the shared story.

How the story connects with the therapists dialogic-self.

How that observation promotes the emergence of empathic observations and connected reflections towards the client group by the therapist:

Example 1: Line 221-228:

Kathleen: "I think I might ask them about their current experiences and where I fit with it because there are a lot of people in their lives and how that makes them feel and what it is like to have conversations with so many people".

Through the process of observing the client group encounter through a dialogical lens it supported Kathleen to revisit and revise how she understood the stuck episode. Through the dialogical observation, Kathleen reflected on how she had formerly attended to the clients shared stories. She reported, "I realised that I was working hard to convince a family that I have the answers" [post consultation: 30-31], to how she was now more mindful of her prejudices and how she connects with the family. She cited " It allowed me to see them as parents who want the best for their children...it allowed me to provide space for the family voice...to consider hearing their stories differently" [post consultation: 168-170]. Hence, to observe a therapeutic encounter through a dialogical lens highlights the multiple perspectives and the interconnected processes. Stuckness then translates into a phenomenon that has multiple interconnected factors [see Flaskas, 2009]. Furthermore, as demonstrated by Kathleen, to observe stuckness through a dialogic lens offers multiple ways of reflecting and moving forward:

Example 2: Line 233-250:

Kathleen: "And maybe another question that I may have is to ask them about their family of origin because I have tried to get them to talk about it ...but we never got there...and that's when I start to think of my own experiences and my expectations of them...although it might

not fit with their experiences...and I suppose I see a shift in me ...with my own parenting and how I see them through my own experiences of being parented and now I am a parent".

The analysis will continue with a discussion on the emergent themes:

Theme 1: Therapist's therapeutic observation and therapeutic-use-of-self: A dialogical observation:

Kathleen's engagement with the consultation brought forward strong emotions with a central image of motherhood and nurturing leading the self-reflections. This reflexive activity supported the therapist to reflect on the family in a way that highlighted their uniqueness and humanness. It shifted the observation from a theoretical and systemic lens to a connected lens. However, this process, on reflection of this consultation, entailed a number of reflexive steps: Firstly, Kathleen reflected on the client group as supported by the professional and systemic domains of inquiry. Kathleen then reflected on how the stories connect with her as a therapist and as an individual, as supported by the experiencing-domain of inquiry:

Example 1: Line 144-150:

Kathleen: "Well I suppose what I am thinking about is my experiences of being parented and I wonder did they experience or what experiences did they have and how does that come out in their day to day life".

Example 2: Line 191-197:

Kathleen: " I suppose when I listen to the family and hear the stories of how they care and look after each other and I think of my experiences...I wonder how I understand that or what that meant and how does it reflect with what I hear from this family".

Next, Kathleen reflected on the client's story, her story, how they connect and how she can finds ways to move forward in the therapeutic trajectory:

Example 1: line 239-255:

Kathleen: "And that's when I started thinking about my experiences of myself and I consciously reflect back on my experiences and their experiences and my expectations of them...although it does not appear to fit with their experiences ...and I suppose I see a shift in me...maybe influencing how I see this family, that is being a parent brings another new idea of how I can connect with them".

Thus, the reflexive process moved through 4 phases [see Rober et al, 2008a, 2008b]:

1. An observation of the client group and the stories they share.
2. An observation of how the therapist connects with these stories.
3. An observation of the client group and stories shared on reflection of how the therapist connects with the stories with the emergence of empathic reflections.
4. An observation of the empathic reflections[48] and how they can support response-building reflections.

Thus, the reflexive process is an activity that brings together the therapist therapeutic observation-of-self and the therapist's therapeutic-use-of-self. This reflexive process as seen in consultation 3 and 4, brings forward new ways of engaging with the client group.

Theme 2: Consultation as a story construction process that is guided by the 4 phases of reflection:

Kathleen's consultation, similar to consultation 2 and 3, told a story. Reflecting on consultation 2, 3 and 4, the experiencing-self of the therapist held each story together. It appears to be the silent central. Kathleen's consultation advances this idea. The 4 reflexive phases creates structure to the story. This idea reflects Rober et al [2008a, 2008b] theoretical discussions following the completion of a grounded theory research project on how therapists think in practice.

Furthermore, and in light of Kathleen's consultation, the storytelling process supports the formation and strengthening of the meta-observational position. This position directs the therapist to focus on where the therapeutic trajectory is at. More importantly, this position brings together the experiencing domain of reflections [i.e. the therapeutic observation-of-self with the therapeutic-use-of-self] with Kathleen observing her dialogic-self as emergent in therapy and outside of therapy: " I think that maybe I need to take a deep breath and maybe link in with myself and where I am at" [post consultation: 283-285]. Therefore, it not only promotes a renewed attentiveness to the presenting client group but also a renewed interest in the dialogic-self of the therapist. The meta-observational position from this consultation arises as a more complex position. Kathleen reported at the post consultation meeting "such

[48] I do not imply that empathy/empathic observations are the only constructive observational position. Other positions can occur that illustrate the authentic identification of the therapists, client group and connections; and of which, can produce new insights and new ways of proceeding in the therapeutic trajectory [see Pocock, 2005; Rober, 1999, 2011].

reflections allowed me to consider my own beliefs, values, and expectations of therapeutic change" [post consultation: 8-9] and subsequently supported an "emotional connectedness" [P.S. 2] form of engagement with the client group.

5.4. Post consultation 4 observations: Therapist and researcher dialogue:

Kathleen shared her thoughts on how engaging in the consultation altered her way of observing systemic practice. Kathleen made reference towards the experiencing-domain questions and how they brought to her attention the value of an emotional connectedness with the client group and how that form of connection supports ways of engaging that fit with the family: "It allowed me to see them as parents who want the best for their children...it allowed me to allow space for the family voice...to hear their stories differently" [post consultation: 168-170]. Kathleen shared that "I believe in the future it will alter the style of dialogue that I have with families...I will try to actively recognise the positions and emotions that I bring into the room" [post consultation: 43-46]. This responds to the opening question regarding the experiencing questions and how they fit within a research project. Kathleen brought to this consultation a genuine interest in the client group. She looked for ways to support this family. She drew on her historical-self as prompted by the model. It brought forward new ways of connecting. Therefore, I believe, it was a helpful activity for Kathleen. Did she feel supported? To return to the non-disclosure theme, for this consultation, I moved towards a more dialogical mode of participation. The model also underwent modifications with a shift towards a more balanced dialogical/cognitive frame. I believe these changes supported Kathleen to share her experiences. A difficult task in light of the limited time and the unknown aspect of the process for Kathleen.

5.5. Post Consultation 4 observations: Gadamarian hermeneutic lens as filtered through the Action Research observations:

It is interesting how each participant is surprised how his or her *self* plays a part in the therapeutic trajectory [selected highlight]. Teresa shared "when I hear myself talking I am a bit surprised with myself in that I suppose it is the assumptions that I have" [241-246]. Michael spoke of the need to focus on the client group and not the therapist. However, as each participant engaged in the consultation they reflected on how connecting with their dialogic-self supports an "emotional connectedness" [Kathleen: P.S.2.] with the client group, a process that "helps to find questions" [Michael: 169]. This process highlights the human

aspect of therapy. The emergent emotions trigger empathic reflections, which in turn support empathic responses. This observation is important in relation to the model development. At this stage of the research, I am more at ease with the consultation process. Initially, I strived to find answers from the participants. Now I am content to sit with the participant and observe how they engage with the questions. It has become a nurturing process rather than an investigative activity. How will this translate to the broader systemic environs?
I am moving into consultation 5. As for consultation 4, the P.S. will be included, at the start of the model and at the close of the model. As noted, the P.S. activity supports the meta-observational position, a position whose description is becoming more complex in response to the participants reflections.

6.1. Consultation 5: Elizabeth.

Elizabeth participated in consultation 5. I acknowledge that this consultation was rushed. For example, I omitted the position statements, and from a retrospective position, the omission, I judge, was unhelpful to the overall consultation outcome. A learning process for me. However, possibly not for the participant. However, this consultation did provide theoretical ideas that supported the development of the model. The ideas will be incorporated into the analysis.

The analysis will again commence with the pre consultation 5 observations:

6.2. Pre consultation Gadamarian reflexive observations as filtered through the Action Research lens:

The overarching aims of the Consultation Model have evolved. These aims evolved in response to how the participants engaged with the consultation format. First, each participant demonstrated a direct interest in how they observe, connect and engage with the client group [see Rober, 1999; Rober et al, 2008a]. Thus, the aims of the model expanded with an inclusion of how to support the therapist to move towards a reflexive activity that brings together in an inclusive, responsive environment all of their ideas and self-reflections with all aspects of the family group, their stories, experiences and expectations [see Rogers, 1951, 41]. Secondly, each participant up to this stage of the research demonstrated a reflexive trajectory that encompasses the four interconnected reflexive phases that reflects the ideas of Rober et al [2008a, 2008b].

To achieve these aims the model format was amended. The aim of the amendments was to amplify each reflexive phase thus supporting the therapist to engage with all aspects of their dialogic-self, the client group and the therapeutic trajectory. This activity supported the development of a broader description of the family meetings and in link, a dialogical observation of the stuck phase. Thus supporting new ideas and ways to proceed.

The following discussion will observe if these model adjustments supported the therapist to observe all aspects of the client group and how they engage with the family. In addition, the discussion will examine if these changes supported the therapists to generate new or alternate ways of transcending the stuck phase:

6.3. Interpretative Phenomenological Analysis:

In order to place the stuck episode into context, Elizabeth at the opening of the consultation, described her therapeutic journey with the client group. Elizabeth opened her reflections with the idea that when families are referred to a clinic they already carry a "clinic picture" [22] that has the potential to define practice. For this family, the story was about the young girl's non-school attendance. Therefore, according to the clinic picture, Elizabeth's task was to support the young girls return to school. Elizabeth undertook this responsibility, but found that the client group had difficulties in achieving this task. In response, Elizabeth shared that she felt "a sense of hopelessness" [20]. Thus, the professional responsibilities, as dictated by the clinic picture and the family's difficulty in achieving this task, triggered the stuck episode: "I suppose it's not myself but it's something that comes from work… [Pause]… The need to get the child back to school" [130-133].

As we stepped through the consultation, Elizabeth explored how the professional voice dictated her meetings with the family and how it overshadowed all other aspects of their story. She touched on her systemic ideas and felt a tension between trying to be systemic and being tunnelled into professional demands: "The girl had latched onto not been in school and the mother had held onto that in the sessions" [37-43], but at the same time wondering about "what were her stories about....I kind of had to bring myself back to hear her stories because I had heard that she wasn't socialising [12-15].

The systemic reflections brought into focus the subliminal or silent experiencing voices: "I'm kind of thinking about nurturing" [79]. I responded with "This is a different story" [88-92]. This reflection prompted Elizabeth to step back from the professional expectations and let the family's story unfold. The following question again prompted the systemic lens: "What

questions have you not asked so far?" with Elizabeth posing: "I suppose I haven't asked them questions about them as individuals" [113-117]. The dominant theme lost its grip with Elizabeth reflecting on the idea of "starting afresh" with the family and sharing: "I will revisit the whole family and get to know the whole family...and I think that it is worth doing" [122-124]. The empathic reflections prompted Elizabeth to observe herself as a therapist and as a distinct person "Yea and I think it has helped me to touch base with myself" [151-154].

This dual observation, of self and other, supported Elizabeth to find ways to move forward:
Example 1: Post consultation: Line 91-92:
Elizabeth: "But I like the whole idea of looking at yourself and what it is because normally I look at what the clinic will look for ...say like returning to school".

Example 2: Post consultation: Line 113-115:
Elizabeth: "It is good to take time to reflect on and return to the human side of ourselves and our own life experiences, which influences our actions and reactions in our shared communications as therapists with our clients and not to get caught up in theories and others views, team and society, without a consideration of where they have come from".

Hence, professional expectations can dictate the therapeutic focus and delineate unachievable goals that can overshadow other aspects of the client's story. Thus, stuckness for this family arose in response to one aspect of their story dominating their therapeutic meetings. The consultation process brought into focus other aspects of the client group and thus opened new lines of dialogue. In addition, the model prompted Elizabeth to observe herself and view this observation as a useful therapeutic tool:

Example 1: Post consultation Line 54-55:
Elizabeth: "I realise with reflection that I was inadvertently being a vessel for encouraging this [dominant theme] and was holding these thoughts and ideas in session, which the family were holding and seeking to achieve, without allowing space for a different way of moving forward".

Elizabeth's consultation illustrated how the developing model can:
First, prompt an exploration of how the family's opening description and existing therapeutic approach can prompt a stuck episode.

Secondly, prompt multiple reflections that simultaneously strengthen themes that had been overshadowed and weaken themes that had dominated therapy thus supporting a move towards a more fluid therapist self-dialogue and therapist/family dialogue.
Thirdly, prompt a reflexive process that supports the therapist to step back metaphorically, view the stuck phase from a multiple of perspectives and find new ways of proceeding.
For Elizabeth, the consultation prompted new ways of reflecting and a revisiting of old ideas. Thus to address stuckness through a dialogical consultation model can be a catalyst to change:

Example 1: Post consultation: 86-87:

Elizabeth: "My thoughts and ideas were re- energized which had an impact on the [family] dialogue through my questions considering the mothers role as a mother and her thoughts that she had failed her children and her husband".

Example 2: Post consultation Line 9-14:

Elizabeth: "I decided also as a result of my initial interview with Hannah[49] that I was going to invite the couple to the session alone, which is something that had happened in the past on one occasion and when I reflected on that session I remembered it been very interesting and bringing up lots of avenues for discussion and consideration between the parents about their lives together when they were younger and how things evolved for them".

6.4. Post consultation Gadamarian Lens as filtered through Action Research:

Emergent themes:

1. The internal dialogue: A compilation of reflexive compasses:

At the beginning of this project, I looked at developing a consultation model that drew on the internal dialogue. The original model drew on a description of the internal dialogue that comprised of isolated voices that could be mechanically manipulated. On reflection of the consultations, I now believe that the therapist's internal dialogue is a more complex composition. I now judge that it can be described as a multi-layered composition that does not wholly draw on the systemic, professional and experiencing-self voices, but incorporates

[49] Pseudo name.

a multiple of layered connected reflections that are difficult to define or isolate [see Michael et al, 2008]. I believe, there should be no division, for to understand one is to understand the other. To illustrate, I will describe the moral compass position. Each therapist to this point of the research has included the moral compass position.

This voice provides a self-critical position as seen in consultation 2 and 3:
Example 1: Teresa, Line 98-103:
Teresa: "I feel that maybe there is too much emphasis on the therapist to always come up with the questions and that maybe it's good for me to leave it open for the family to join in" .

It can close off narratives a seen in consultation 2 and 4:
Example 2: Line 465:
Teresa: "It is my own strong values about what a family is about".

It can bring forth silenced narratives:
Example 3: Kathleen, Line 191-197:
Kathleen: "When I listen to this family and hear the stories of how they care and look after each other and I think of my experiences...and I wonder how I understand that or what it meant and how does it reflect with what I hear from this family".

It can raise questions and offer guidance as in consultation 2 and 3:
Example 4: Michael, 54-56:
Michael: "How do I listen so that I am in a sharing space with her"?

However, it is not possible to differentiate this voice. It has attachments to all other reflection[50]. How do I translate this idea to the model development? The idea of introducing reflexive questions that do not necessarily draw on specific voices fits more with the idea of a complex internal-self and has arisen as a key theme throughout the project.
However, the internal-dialogue expression is complex with multiple identities integrated into *a continuously evolving self-story that does not include a well-ordered turn taking process* [selected highlight] [see Michael et al, 2008]. To observe and generate a self-reflexive

[50] It can act as the silent partner, act as the catalyst to change, or, support the evolution of new reflections within connected positions.

dialogue is difficult. Therefore, in order to support the therapist to begin observing their unique internal dialogue, I will continue to include the model questions that isolate the voices. I believe it is a first step in self-observation. This form of question will be balanced with reflexive questions as guided by dialogue and Gadamarian ideas [see Appendices 8 and 9].

2. The meta-observational position: A dialogic observation:

This position has developed as the project continued. The original description detailed a collection of ideas and reflections contained within a cognitive observational space. As the research moved into the fourth and fifth consultation, it emerged that the meta-position can be described as a cognitive space that continuously evolves. This cognitive movement can be understood as a developmental process:

Firstly, the therapist brings together and observes all self-experiences systemic reflections [to include expectations and shared stories of client group] and professional guides.

Secondly, the therapist observes how they communicate with each other.

This process initiates an empathic phase that incorporates an observation of self-of-therapist and client group and how best to move forward for self, for other and for therapeutic process:

Example 1: Post consultation: Line 105-106:

Elizabeth: "The use and reflection of the self of the therapist is key in this and can be helpful in promoting a change in question focus or a sharing of experience".

Example 2: Post consultation 3: Line 397-400:

Michael: "And the thing is about listening, it is the same conversation that we had the last time but it is different in that it was different for me because I was listening differently in that I am more attentive in not only what I was saying ...like something around letting the conversation to happen in the moment rather than me leading the conversation".

The P.S. supports this process. Therefore, it will be re-introduced into the model format.

3. Consultation as a shared reflexive space:

I have had the opportunity to revisit Jones [2003]. This paper explores the task of a consultation and suggests that a "consultee seeks out a consultant in order to use the consultants views, experience and skills and meta-position, so as to gain new perspectives on their work" [2003, 7]. Why did I revisit this paper? At the start of this project, I was pulled between taking part in a consultation and in the process of conducting research. They are very

different tasks. Each seeking a different outcome. I found it difficult to balance the two tasks. I found myself leaning heavily towards the research task in consultation 1, 2 and 3. With consultation 4 and 5, I felt more drawn to the consultation process. This shift was triggered by the amendments to the model format with the inclusion of the phenomenological and dialogical style questions and a reduction of the cognitive formed questions. I found with interest, that during the course of consultation 4 and 5, I had the opportunity to ask responsive questions. This activity introduced a shared intersubjective space. Is it beneficial to the model? It would appear helpful. For the first two consultations, my position as a researcher overshadowed this vital aspect of the consultation process. In response to the changing perspective and subsequent changing format, the model has moved towards a shared reflexive process rather than an observer – participant consultation process. An activity that I believe is helpful to the participants, and myself, and one that fits with contemporary systemic practice.

6.5. Post consultation 5 closing notes:

I have reached the final consultation. The aims of the model have evolved. I would hope that the model now resembles a preparatory process, the process of which is more important than the outcome.

The aims of the dialogical model at this phase of the project are to support the therapist:

I. To move towards the development of a meta-observational position, as developed through the externalising of the community of internal voices, which enables the therapist to view all voices or in systemic terms, all ideas, reflections and self-experiences[51] and their relationships in a more transparent environment, with the aim to work towards a community of linked observations that will create a multiplicity of thought and a flexible perspective to family or client group stories and dynamics.

II. To support the therapist to move into a reflexive trajectory that encompasses and articulates an interest in the family experiences, historical and emergent stories and how they connect with the therapist's reflections and observations with the generation of empathic reflections [i.e. an interest in the family experiences, stories and expectations].

[51] This aim endeavors to support the therapist towards an enhanced insight into how they position themselves in relation to the identified client group through the exploration of the internal dialogue with emphasis on their experiencing reflections.

III. To support the therapist to move into an inclusive response building reflexive activity that appreciates and welcomes all ideas, both client group and therapist, sees all as worthy with a Gadamarian movement between all observations, reflections and ideas.

The final consultation provides an opportunity to observe if the evolving aims of the model are achieved:

7.1. Consultation 6: Johanna:

Johanna engaged in the final consultation. As the consultation progressed, it emerged that Johanna, similar to the previous participating therapists, illustrated a predisposition towards constructing a story, an activity that appears to support the therapist to move through the identified reflexive phases [see Rober et al, 2008a, 2008b].

Once more, I will follow the identified analysis framework and thus commence with my observations:

7.2. Pre consultation observations as guided by Gadamarian Hermeneutics:

During the course of this project, I have been interested in how and why the participants employ non-disclosure mechanisms. I have suggested that the therapists employed these strategies to evade exploring the self-experiencing domain questions. This interpretation fits with my prejudices in that it ignores the developmental errors and oversights in the model format that may prompt non-disclosure. This interpretation overlooks the perspective of the participants. This observation raises questions regarding the analysis to date.

In response, how do I orientate myself towards an observational position that is not solely directed by my prejudice[52]? Hermeneutics of empathy and questioning [see Smith et al, 2009[53]] provides two broad interpretative positions that may further assist me to approach the final consultation in a more open position. To translate, these interpretative positions involves, me the researcher, adopting two positions: One, stepping in to the shoes of the participant or adopting an insider perspective [Smith et al, 2009, 36]; and two, "standing alongside the participant, taking a look at them from a different angle, ask questions and puzzle over things they are saying" [Smith et al, 2009, 36]. Hence, to re-read the non-

[52]Again, this discussion brings forth the ideas of Gadamer [1990/1960]. Gadamer [1990/1960] advocates that the prejudice or horizon of the investigator contributes to the investigation, it creates the parameters of interest or directs the lens of inquiry and the meaning ascribed to the data.

[53] See Smith et al [2009, 36] interpretation of the ideas of Ricoeur [1970].

disclosure analysis from a position of empathy and questioning, what if the therapists use broad systemic ideas and professional lexicon when they are unsure of what the model questions are asking of them, or, when they find it difficult to deconstruct their inner dialogue, and thus, isolate their experiencing-positions[54]? With this thought, during the course of the analysis, I will observe the use of non-disclosure strategies from the participant's position.

The phenomenological observation and analysis again will commence with an observation of the participants description of the projects theme and will then explore how this description evolves in response to the model.

7.3. Interpretative Phenomenological Analysis:

Johanna commenced her consultation with a question: "The question is who is my client and I think about therapeutic thrust" [11-18]. To place this question into context, Johanna shared that the parents requested support for their daughter. Thus, the therapist understood that she would engage solely with the daughter. The parent's expectations were different. They sought continuous feedback. Therefore, for this therapeutic activity stuckness emerged when the therapist felt that the confidentiality boundaries were insecure. This dilemma affected on the trust building process and subsequently on the therapeutic trajectory. Johanna reflected on her position and identified two interconnected therapeutic barriers: "Well, it's like I'm trying to work and at the same time balance confidentiality" [54-56]; and, "So I think about space or think about therapeutic thrust and I wonder how I fit in" [13-15]. Thus, Johanna's initial description defined stuckness as arising from one aspect of the therapeutic process i.e. confidentiality parameters.

As the consultation progressed, the description broadened with a description of how a stuck episode can arise from a multiple of positions. For this case, Johanna illustrated a tension between her systemic [to include family's expectations], professional, ethical and empathic voice [in response to young person's position within family system]:

Example 1: Line 44-58:

Johanna: "The young person has a particular perspective and their perspective is different than mine...and I have ideas...in that I am out of the situation and I can see that there is a difference in perspective which is what I look to do with the young person and at the same

[54] On reflection of the previous discussion on the complex internal landscape.

time when I hear something different I wish they wouldn't have come along to the session like they have a right to feedback and involvement".
The consultation moved into the systemic/experiencing domain questions and although they did not ignite experiencing reflections, they did bring attention towards the internalised-other voice, and in response, strengthen the empathic response voice:

Example 1: Line 59-66:
Consultant/Researcher: "What is it like to sit and hear the stories of this young person?"
Johanna: "Gladness maybe in that they are sharing their stories with me and that they are changing and that I have a responsibility to listen to and trying to work with what they are saying and not saying"

Example 2: Line 74-82:
Consultant/Researcher: "Let's say with this family in what way did you notice that you were moving into a stuck phase".
Johanna: "I think it's when I got distracted from listening...missing from what was been said...like thinking what would it be like for the parents to hear that".

In parallel to the above response, Johanna at times shifted into utilising non-disclosure mechanisms through the process of externalising herself from the family and the reflexive activity:

Example 1: Line 135-139:
Johanna: "Well I do think of the parents and all the work they do, I do like to be helpful, and I do see the teenagers and understand that they do want to be better and yes if I can make a difference".

To observe the non-disclosure strategies from a position of empathy and questioning: First, the consultation process is new to Johanna and therefore she has to find her way through the questions and what they are asking of her. Second, this is the first time that Johanna and I met. The informal conversation prior to the consultation was rushed, a process that does not support the sharing of sensitive information. In addition, if I stood in the shoes of Johanna, I would be cautious when responding to a number of the questions in that I may feel judged.

Moreover, is it that Johanna was possibly wondering how an exploration of the-self fits into a scenario where an ethical dilemma is prominent.

To bring these thoughts together, reflexive work can be challenging and requires time to evolve. From my own experience, I understand that a therapist requires time to absorb and translate reflections at his or her own pace. This point can be illustrated when we view the post consultation reflections. This meeting brought forward new insights. Johanna spoke of how she initially felt a responsibility towards the parents "and their agenda" [post consultation: 2] and how the consultation brought into focus "different people having different ideas" [post consultation: 4]. These different reflections supported Johanna to distance herself from the dominant reflection. Johanna shared that she felt "freed up" [16] or more open to other voices when she next met with the young person:

Example 1: Post Consultation: Line 11-14:

Johanna: "I definitely began to focus more on the words spoken by the young person and became less focused on what was going on with the parents. I think it makes a difference for the young person".

This discussion raises a key theme:

Reflexive activity requires time. To expect the emergence of meaningful observations and thus disclosures at the consultation phase is unlikely. However, Johanna illustrated reflexive activity post consultation in response to the consultation. The other participants demonstrated a similar activity:

Example 1: Post Consultation 3: Line 78-88:

Michael: "And that about me that I thought about on the last day [consultation] I was having these parallel conversations in my own head about my own children and just about what it was like, like what do you say to them...this raises a lot for me in my own life".

Example 2: Post Consultation 5: Line 54-56:

Elizabeth: "I realise with reflection that I was inadvertently been a vessel for encouraging this and was holding these thoughts and ideas in the session without allowing space for a different way of moving forward".

The question that arises is how to promote post consultation reflection? As previously noted, the use of questions that the therapist can absorb into their reflections post consultation and act like horizon catalyst are helpful.

For Johanna's consultation an example is:

Example 1: Line 229-239:

Consultant/ Researcher: "I am going to ask you a question with that in mind...what questions do you think you could ask"

Johanna: "Well I suppose I haven't asked about other family members...Well I suppose I haven't looked at the young person as a part of a system ...the young person and the parents...and the young person as part of the wider family and the siblings".

To bring the analysis together, Johanna at the opening of the consultation posed the question: "But part of me is saying what is my role?" [P.S.1.]. This reflection brought into focus the professional, ethical and systemic voice. As the consultation progressed, it brought into focus the voice of the young person and the family system: "I suppose in systemic terms the very nature of the young person within the family...the parents bring them too therapy...and sometimes I am very conscious of that" [116-118]. This activity prompted empathic reflections and created empathic ways to go forward with the therapeutic trajectory. It did not resolve the ethical and systemic dilemmas but supported the therapist to bring all reflections to a meta-observational platform, sit back, reflect and almost start anew:

Example 1: Position Statement 2:

Johanna: "I suppose going to the question about what is my role ...I really feel that I don't need too as much...it's ok to leave that open as we go along….. She is getting better but her parents don't feel that she is but that is something that we can bring into a family session...I don't need to be focused on sessions as much".

Example 2: Response building phase, Line 260-266:

Consultant/Researcher: "Has it influenced how you may observe or connect with the client group?"

Johanna: "I certainly would maybe try something in relation to the parents...let's say the wider systemic ideas I feel that it was that cross over to the parents that was making me feel stuck".

7.4. Post consultation Gadamarian observations as filtered through Action Research lens:

This consultation revisited themes that emerged in the previous consultations:

Firstly, Johanna entered the consultations with the thought that the stuck episode was triggered by an ethical dilemma. This description broadened as we stepped through the various domains of inquiry with professional and systemic ideas supporting a multi-axial description. Similar to the reflexive framework identified by Rober et al [2008a], Johanna moved towards reflecting on the internalised-other as triggered by systemic ideas. This reflexive activity triggered empathic reflections. All reflections were united with the P.S. providing a platform from which to view all reflections and their relationships. From this observational position, alternative ways to proceed were identified. Thus, in light of all the consultations, the model supports the therapist to step back from the therapeutic environment, observe and articulate all reflections, develop a reflexive story, and from that position identify ways of meeting with the family group that helps to transcend the stuck phase.

Secondly, Johanna at times employed non-disclosure mechanisms similar to all other participating therapists. I have identified possible causes. On reflection of all the consultations and in light of the complex stories shared, I believe that the use of these strategies highlight the difficulty that the therapists experience when deconstructing the internal dialogue, a composition that is complex in response to the complex environment of family therapy.

How do I translate these ideas to the model construction? This theme will be addressed in the following chapter.

7.5. Closing note:

The analysis is complete. This section observed how therapists describe stuckness and how this description responds to a dialogical consultation. I observed how the participating therapists engaged with the Dialogical Model and modified in response.

What is the outcome of the consultations? My thoughts are that the dialogical model supports a therapist to develop a meta-observational position where all reflections, including therapist–observation-of-self, as triggered by the dialogic-other, are gathered to create a reflexive platform where different ways of observing the therapeutic encounter arises. This process supports new ways of engaging with the client group. This process supports the therapist to transcend the stuck phase.

The following chapter will discuss the emergent themes. It will complete the chapter with an overview of the model and close with a critique

CHAPTER 7:

A DISCUSSION ON THE EMERGENT THEMES AND AN OVERVIEW OF THE DIALOGICAL CONSULTATION MODEL:

> "Slowly and beautifully the land loomed out of the sea. The wind came again. It veered from the northeast to the southeast. Finally, a new sound struck the ears of the men in the boat. It was the low thunder of the surf on the shore".
>
> Crane, 1887/2010 [Electronic Edition].

1.1. Introduction:

Chapter 7 brings together the discussions that have emerged in response to the model development. It comprises of four phases. First, I will look at how we can now understand therapist stuckness. This description will be followed by a look at how this phenomenon can be addressed through a consultation process. The therapeutic value of the model will be defined. The opening phase will direct us towards the emergent themes with an overview of how they influence the model construction. The chapter will finish with a synopsis of the modified Dialogical Consultation Model and conclude with a critique of the presented model.

2.1. Dialogical conversations in a consultation process:

Therapist stuckness:

In response to the research, how can we now describe therapist stuckness? To describe stuckness, it is helpful to track how it emerges and to illustrate its movement, rather than defining it in static form. Hence, stuckness can arise at any phase of the therapeutic trajectory. It has the potential to emerge when the family group, the dynamics they bring to the encounter, the stories they share, and, how they observe and connect within the therapeutic space, comes together, with the therapist's autobiographical past, their present, and, how they witness the family stories shared, in a way that constrains dialogue. Thus, it is a responsive process, in that, it arises from how the therapist and family group connect, relate, and respond to each other.

To place this definition into the context of contemporary systemic practice, two terms will be explained. The term dialogic activity, as applied to systemic therapy, is a process where the therapeutic intention is for all participating parties to engage in a co-created, reflexive conversation, with an aim to bring together all reflections, and from that observation, create dialogical openings within the therapeutic encounter. The term, dialogical activity, can be further deconstructed and understood as a responsive process. The term, responsive process, as applied to systemic practice, can be understood as the emergent complex interaction between the client group and the therapist's multiple ways of observing, witnessing, connecting and participating in the therapeutic trajectory. Each observation, connection and witnessing process, is influenced and influences each other observation. Each observation supports a reflection. Each reflection supports a response. Thus, it is a responsive environment, where each reflection and response has two tasks, too build on the preceding response and too create dialogical openings.

Therapist stuckness arises when the dialogue within the therapeutic process is shaped by therapist reflections that do not connect with the emergent co-formed dialogue, or, that do not create dialogical openings. This highlights that therapist stuckness cannot be described as a linear, isolated factor, but as a potential feature of a dynamically, evolving, co-formed system

Furthermore, during the course of this project, each consultation demonstrated a unique therapeutic story with a unique responsive process dependent on the self-of-the-therapist and the client group, as active players in a co-constructed system, who bring with them their complex personal selves [see Aponte and Kissil, 2012]. Thus, it is a responsive process that is unique to the particular stuck episode.

2.2. In what way can a dialogical consultation model support a therapist when they experience a stuck phase?

This project has highlighted the complex process of how systemic therapists engage in self-reflexivity as a component of the consultation process. A consultation model was developed in response. What is the potential therapeutic value of the dialogical consultation model?

The model in practice supports a number of therapeutic activities. The supports are as follows:

The construction of a story:

The participants illustrated that they use the construction of a story to bring to life their engagement with the client group. The storytelling process is multilayered with each layer influencing and influenced by the other layers. The storytelling process is held together by a number of reflexive activities, with the meta-observational position providing an overarching guiding and encompassing watchtower. The construction of the story can be understood as the overarching task and is guided by the four reflexive phases as identified by Rober et al [2008a, 2008b]. These phases provide the therapist with a road map or signposts of how to progress through a therapeutic encounter. The consultation model supports the therapist to engage in all aspects of the therapeutic encounter in a manner that highlights the relationship between the different aspects, characters and experiencing themes of the story, the therapist's self-reflexive domain, and, how they connect.

The construction of a meta-observational/ reflexive position:

For a consultation process to be useful, it must observe and address each domain of the therapeutic encounter:

- ✓ The stories shared by the client group.
- ✓ How the client group observe their stories, experiences, and, expectations.
- ✓ How the therapist observes the family story.
- ✓ How the therapist connects with the family group, the stories they share and the therapeutic encounter.
- ✓ How the therapist shares that understanding with the client group.
- ✓ How the client group observes and responds to the therapist's response.

The developed model addresses each domain. The model also supports the therapist to observe the connections between each domain. This reflexive activity supports the therapist to generate a meta-observational position that takes into account all aspects of the therapeutic encounter. Through the development of a meta-observational position, the therapist can step back from the stuck episode, generate a holistic orientation to the family, the stories they share, and the intersubjective space, and from that reflexive position, generate new ways of moving forward in the therapeutic dialogue.

Therapist-self reflexive support:

The consultation questions draw from different perspectives. They are different questions with different tasks. First, the consultation poses questions that draw from the cognitive field

of science. These questions support the therapist to define the components and/or the themes of the family story. Second, the consultation poses questions that draw from the dialogical perspective, as influenced by the horizon concept [see Stern, 2003]. These questions evoke the family's story and the therapist's internal dialogue in response to the therapeutic encounter, which supports the therapist to connect with their-self, in response to the therapeutic environment, and the family, in a more meaningful manner. This reflexive process activates different ways of observing and connecting with the client group. It has the potential to ignite empathic observations. These observations support the therapist to find new ways to become part of the therapeutic story, and new ways to progress the therapeutic dialogue:

Example: Therapist self-reflexive questions:
Qu. 5: "What is it like to sit with this family and hear their stories?"

To conclude, family therapy, as a practice, embraces a holistic perspective. This perspective recognizes the uniqueness and depth of each encounter. For each family therapeutic meeting it stresses that the whole is greater than the sum of all the parts. Thus, the process of engaging with a family requires a conversational process that supports all stories, perspectives and qualitative differences, to emerge [see Sheehan, 1999]. Primarily, the consultation model is based on reflexive storytelling. It shifts the consultation focus from the stuck phase to a witnessing of the family encounter and how the therapist is positioned within that process. The therapeutic value of the model is its potential ability to support the therapist to step back from the stuck phase, revisit the family story, and from that activity, open space for new ways of observing.

The consultation model attempts to bring forward the uniqueness of the therapist, and, how that unique voice, can support new ways of connecting with each family encounter [Rober, 1999, 2005b]. The consultation model supports the therapist to observe their-self, as emergent within the family encounter. The therapeutic value of the dialogical model is its potential ability to create a reflexive space for the therapist. For the therapist, it has the potential to open new reflexive horizons, and thus, new ways of observing and connecting in systemic therapy.

This discussion has looked at the therapeutic value of the model. To conclude this discussion, it is important to define the purpose of the model. At the start of the project, the model was developed solely for the consultation process. Current descriptions describe the consultation

process as a dialogical activity. The developed model supports the generation of a holistic description of the family and supports the therapist to observe how they connect with the family and the stories they share. The model style does not support a dialogical consultation[55] [see chapter 7, 8.1]. Thus, on reflection of it style, the model can be used as a therapist self-reflexive tool or as a preparatory step towards consultation rather than as a consultation tool. In addition, it may also be a useful tool for trainee family therapists.

This chapter opened with a description of therapist stuckness and how it can be negotiated through a consultation process. The discussion concluded with an overview of the potential therapeutic value of the developed model.

The following section will develop the key themes that influenced these descriptions.

3.3. A development of the super-ordinate themes[56]:

Theme 1:

The internal dialogue: A complex composition:

This project has observed the complex internal dialogue of the therapist as they engage in a consultation process. From this study, it can be put forward that the internal dialogue composition is a more complex environment than what was initially suggested [see Dreyfus and Dreyfus, 1990]. It is a composition that does not lend itself to a defined structure. It is unique to each therapist and to each encounter. Therefore, it is difficult to observe and translate. However, although we cannot provide an accurate account we can provide a description that helps a therapist to observe how they connect with the client group. Thus, the internal dialogue can be described as a combination of reflexive compasses that are influenced and influence each other, with at any one time, a combination of compasses directing the therapeutic observations and interpretations. In addition, there appears to be an oscillatory type movement between the compasses, with in response, an environment that continuously revises itself with a strengthening of attachments or weakening of attachments between the various compasses. Thus, it is an evaluative system.

What will this description bring to this project? To return to the original description and to my initial reading, to conceptualise the internal dialogue as a set of decentered voices, loses the dialogical aspect of thinking and reflecting. This description puts forward limited ways to

[55] Refer to the developed short version of the model [see Appendices 10] [see Burck, Barrett and Kavner, 2013]. This version supports a dialogical form of consultation.

[56] See Appendices 6 and 7 for theme development.

advance. To view the internal dialogue as a cast of reflexive, connected compasses highlights the responsive and reciprocal aspect of reflecting and connecting. I believe this is a useful image for therapists observing their internal dialogue. It provides an image that helps therapists to observe the multiple components and perspectives of the therapeutic encounter, and how they interact, an image that promotes therapeutic movement.

These ideas are not new and do challenge the opening suggestion of how to support a therapist encountering a stuck episode i.e. what is the value of including direct cognitive style questions. To respond, I argue that the internal dialogue is multi-layered with multiple meanings of which only the author can truly understand. To translate the internal dialogue from the therapeutic environment to the consultation process is difficult. The cognitive questions support the therapist to develop a basic internal representation of how they are connecting with the client group. This structure provides the first step in a complex process.

In continuation with the internal dialogue theme, I will look closer at the client group voice:

Dominant voices in the systemic encounter: The client group voice:

For the initial consultations, I attempted to focus solely on the therapists' reflections believing that the client-voice could be isolated from this process. The early consultations illustrated that it is not possible to isolate this voice. Rather, each research participant demonstrated that the client voice holds a central position in his or her internal dialogue. This voice brings together the family stories and expectations, and, the family's ability or readiness to move into or explore their experiences through a systemic lens. In addition, this voice ignites the therapists here and now self-experiencing reflections, which in turn ignites the therapist's historical-self-experiencing reflections, which in combination have the potential to stimulate empathic observations and reflections, and thus new ways of observing the therapeutic encounter. However, at this stage of the model development, I judge that I continued to undervalue this voice. In response, I have amended the model format and added a question to address this concern:

See Appendix 9: The Dialogical Consultation model in practice:

Qu. 2: "Describe how the family observe and/or share their story".

This amendment aims to bring forward the client-voice, and thus promote the development of an intersubjective space that is dialogic and respectful of all parties. In addition, this

amendment aims to reflect how therapists think in action [see Rober et al, 2008a, 2008b]. By matching the model format with how a therapist thinks ensures that the model is fitting for a systemic consultation.

Theme 2:

The therapist's reflexive patterns:

As the project progressed, there was a shift in understanding how a therapist reflects. Initially, I held that the therapist's reflexive patterns entailed, first, an observation of their internal dialogue, the components and their relationships, with second, a move towards a more open, flexible and connected self-dialogue. This description overlooked the position and influence of the internalised–other, a central feature in systemic reflection. The reflexive pattern that emerged reflects Rober et al [2008a, 2008b] ideas.

Thus, the reflexive process can be described as a move between a number of interconnected reflexive platforms [see section 2.2] [Rober et al, 2008a, 2008b].

Theme 3:

The experiencing-self of the therapist:

This discussion will commence with an overview of how the participating therapists responded to the experiencing questions. Firstly, the therapist reflects on the client group. This reflexive activity supports the therapist to observe and reflect on their here-and-now self-experiences, as prompted by the client group. This reflexive activity supports the therapist to connect with their historical-experiencing-self. This phase of reflecting supports the therapist to observe how they connect with their own here-and-now and historical-experiences and from that position support the therapist to observe the client group from a revised self-position. This activity supports the development of empathic observations, followed by empathic reflections, a process that supports new ways to connect with client group[57]. This therapist self-observation reflexive process is dependent on the client group, the stories they share, and how the therapist connects with the family and stories shared [see Rober, 1999].

Thus, from this description, therapist observation-of-the-self, is supported by an observation and critique of how they react to the therapeutic encounter. Hence, in order for therapists to

[57] Aponte et al [2012] in comparison, suggests that therapist self-observation is separate from the therapeutic encounter.

evolve i.e. to become more in tune with how they are positioned within the therapeutic milieu, the task is to observe the other, and thus, observe themselves.
In response to this observation, post consultation 6 model format was again amended with the opening section including questions 3 to 5 that bring to the fore the dialogic-other, a step that creates a reflexive scaffold that encourages the emergence of therapist-self-observations:

See Appendix 9: The Dialogical Consultation model in practice:
Qu. 3: "Describe your journey with this family"
Qu. 4: "Let us look at the therapeutic process…when you sit with this family what do you observe?" Prompt: "What images do you have in your mind when you hear the family's stories?" [See Rober, 1999, 2010, 2011].
Qu. 5: "What is it like to sit with this family and hear their stories?"

To return to how to support a therapist to connect with the client group and thus support a move from therapeutic stuckness, I will draw from an earlier observation. From this project, it would appear that family therapists do not view their ideas, reflections or experiences in an isolated vacuum but rather through a lens, that brings together the client group and the stories they shared with their own emergent reflections. To support this process, the dialogical model prompts the therapist to draw from their own experiences, both the here-and-now and historical, as emergent and in response to therapeutic encounter. This is reflective of Rober's [1999] earlier ideas and this authors/theorists more recent reflexive model [see Rober, 2010, 2011].

Theme 5:

Therapist non-disclosure:

The emerging consultation model in practice aims to support the therapist to move through the identified reflexive phases in a more inclusive way and simultaneously, to develop a meta- observational position. The models effectiveness is reliant on how the therapist interprets the questions and this interpretation is dependent on how the therapist approaches the process of reflexivity. Interestingly, during the course of this project a number of the participating therapists, at times, employed broad systemic ideas and professional orientated reflections rather than exploring their experiencing-self. On reflection of the insights achieved when the therapists did engage in exploring their experiencing reflections, a move away from this activity can reduce the development of new insights, new reflections and new

ways to proceed. I am very aware that a lot was expected from the participants during the course of this project. The consultation process itself was, I believe, demanding for the participants. Furthermore, to approach self-observation within a research environment is challenging. In addition, the model was at its early stages and therefore difficult to read, interpret and thus, follow [i.e. in a reflexive sense]. However, the question that arises is how do you support a therapist to observe their experiencing–self?

Rober [1999, 2010] suggests focusing on the here-and-now experiences as emergent in the therapeutic environment. Aponte et al [2012] place attention on the therapist exploring their core issues outside of the therapeutic milieu. The importance of this aspect of the therapist's journey has been highlighted by a multiple of authors with Satir [2000] suggesting that the therapist cannot support a family through their therapeutic trajectory without fully addressing their own self-hood. In response, I have revisited the model post consultation 6, and again further adjusted the self-experiencing domain questions [see Appendix 9].This will not fully address the question posed but may further advance the model.

Theme 6:

Consultation as a story construction process that is guided by the identified reflexive phases:

Each consultation told a story. The consultation itself pushes the therapist to re-engage with the whole story of the therapeutic journey. It strives to create a comprehensive polyphonic narrative. The experiencing-self reflexive patterns and the broader reflexive phases [Rober et al, 2008a, 2008b] provide a structure to the story. The storytelling process provides an overarching structure and supports the formation and strengthening of the meta-observational position. This position supports the therapist to observe how they are positioned within the therapeutic milieu and from that observation reflect on how they can strengthen the therapeutic relationship and the therapeutic encounter [see Burnham, 2005].

Consultation as a story telling process brings together a synergy of ideas from dialogue and Gadamarian hermeneutics. It is a different form of storytelling. Thus, the model questions should prompt a cohesive dialogic story telling process that leads the therapists through all the different aspects of the story, a process that moves between real time, historical time, and all the characters in a way that allows all to be heard. This is a significant shift from the original project plan. As demonstrated in Appendices 8 and 9. The model format has evolved in response to the emergent themes with particular emphasis towards supporting the therapist to tell a dialogic story.

As an outcome of this project, storytelling appears to be an intrinsic feature of systemic practice. For the participating therapists, it provided a window into investigating the family's world. It moved a static description of a family and the stuck episode towards a three dimensional story that has shape, movement and depth. I am unsure why I overlooked this aspect at the start of the project. Now, as I reach the conclusion it appears to be the most essential feature of the model.

4.1. Aspects of the model that support the emergent themes:

Aspect 1: Model format: The ebb and flow aspect that follows the identified reflexive cycles:

The amended model format supports the generation of a story that brings together the reflexive phases identified. The format, firstly, places emphasis on the dialogic–other in that the questions support the therapist to observe the family group through their lens. Second, the format supports the therapist to observe their internal-self, the historical-self, the here-and now self, the experiencing-self and the systemic-self in response to the therapeutic encounter. This ebb and flow process aims to support the therapist to think about the inter connections with a move towards a response building process.

Aspect 2: Direct cognitive/dialogical questions balanced with dialogical/Gadamarian formed questions:

As noted, a balance between these different forms of questions supports the therapist to identify the components of their internal dialogue and explore their characteristic and position within the reflexive landscape.

Aspect 3: Meta-observational position:

The development of the meta-observational position is supported by the observation and articulation of all reflections and their connections. It brings together all reflections, client group and therapist. Thus, this position encourages deeper reflection with an emphasis on therapist's self-observation, as positioned within the therapeutic milieu, and hence, a move towards the therapeutic-use-of-self in the therapeutic environment.

Aspect 4: The Position Statement:

The position statement evolved as the project progressed. As noted, its task altered in line with attempting to prompt a more phenomenological/hermeneutic/dialogic mode of reflecting. At this phase of the model development, the P.S. is seen as a reflexive step that

strengthens the meta-observational position. The position statement prompts the therapist to sit back from the reflexive process, observe the familiar and find alternate ways to go on.

The development of the model has been explored. The chapter will now continue with an over view of the amended model [see Appendix 9].

5.1. The amended Dialogical Consultation Model:

The amended overarching aims of the Dialogical Consultation Model:

The overarching aim of the amended Dialogical Consultation Model is to externalise the internal dialogical activity of the therapist with the aim to study how they *observe, express and connect* with the client-groups shared stories, experiences and expectations; and within that reflexive activity, observe what they bring to the therapeutic encounter *in response* to the client-group [i.e. their systemic reflections and professional directions], articulate how they *observe and connect* with their here-and-now experiences and their historical-self *as emergent and in response* to the therapeutic activity and subsequently how they participate in the therapeutic encounter [selected highlight].

The task of externalising the internal dialogue is to support the therapist to observe all reflections, to include the internalised voice of the client group. This process will support the therapist to observe new or emergent aspects of their self that arises *in response* to the therapeutic encounter and thus support new ways of observing their dialogical-self [selected highlight][see Rober, 1999, 2010]. In response, the therapist can then observe how they connect with the client group, with a move towards a response building reflexive activity that brings together in an inclusive, welcoming environment, all of their ideas and reflections with a direct interest and responsiveness towards all aspects of the family group, their stories, insights and expectations [see Rogers, 1951, 41].

Moreover, in light of the theoretical influences[58], the model in practice endeavours to develop a consultation process and subsequent reflexive trajectory that by nature is an ongoing process that does not drive towards closure but rather towards a plurality of possibilities [see Sheehan, 1999, 2004].

[58] With reference towards the Dialogical-self-theories and Gadamerian Hermeneutics.

To achieve this, the model aims to support the therapist to move through a number of sequential reflexive activities[59] as identified by Rober et al [2008a, 2008b].

These sequential reflexive steps are as follows:

1. To support the therapist to move into a reflexive trajectory that commences with an interest in connecting with all aspects of the family's historical and emergent stories.
2. To support the therapist to observe, acknowledge and explore all their existing systemic and professional ideas and reflections that emerge as they participate in the client/family session and to treat all as worthy.
3. To support the therapist to move towards an enhanced insight into how they position themselves in relation to the identified client group and the stories shared through the exploration of their internal dialogue with emphasis towards articulating their experiencing reflections as emergent in the therapeutic activity.
4. Empathic reflections: To support the therapist to observe and explore their own self-experiences and how they may support a connection with the client group, and from this connection strengthen the voice of the client group, the stories they have shared and aspects of their story that may have been lost in translation.
5. To support the therapist to move towards the development of a meta reflexive position, [as developed through the externalising process], an activity which enables the therapist to view all voices, to include the internalised-voice of the client group, the empathic reflexive voice, and their relationships, in a more transparent environment, with the aim to work towards a community of linked observations that will create a multiplicity of thought and a flexible perspective towards the client group and the stories they share.
6. To support the therapist to move into an inclusive response building reflexive activity that appreciates and welcomes all ideas and reflections [see Rober, 1999, 2010; Rober et al, 2008a; Stiles et al, 2004].

Objectives of the Dialogical Consultative Model:

[59] As noted, Rober et al [2008a, 2008b] put forward a reflexive trajectory that family therapists move through during the course of a family session. The model format was modified to fit with the identified reflexive trajectory with the aim too broaden each reflexive step that the therapist takes, to prompt the therapist to connect more closely with each step, and, from that activity advance their observation of their self, their position in the therapeutic interplay, and, the client group's position, with a more developed and inclusive observational reflexive lens.

1. The model introduces a structured way to observe the therapist's inner dialogue in order to ensure all reflections are articulated. This structured format will comprise of questions that draw form the cognitive field with the aim to support the therapist to identify the components of their internal dialogue and of dialogical/ phenomenological framed questions, as influenced by Gadamarian hermeneutics [see Smith et al, 2009], that endeavour to trigger a more in-depth, systematic assessment of the stuck experience by the participating family therapist.
2. The dialogical model will include questions that aim to unsettle and challenge the therapists pre-existing portfolio of ideas and reflections, [and highlight the relationship between these dialogues] with the potential to prompt the emergence of new or different ways of reflecting on the stuck phase.
3. The identified reflexive phases guide the model format. The aim is to promote an internal communicative process that encourages a back and forth movement between the clients groups voice, the therapists professional, systemic, historical and the here-and-now-experiencing reflections, and the emergent dialogic voice, a reflexive process that encourages the therapist to look at each reflection, its position within the internal composition and how it responds with or interacts with the other ideas and observations etc. [see Rober, 1999].
4. The Position Statements [see Cunha, 2007] will offer the therapist a meta-observational/reflexive position from which to step back or gain some distance from the stuck experience and the developing dialogue of the experience as prompted by the consultation, observe their position, reflect, and *gather their thoughts* [selected highlight] and from that reflexive activity endeavour to provide an opportunity for evaluation and a view of alternative reflections and ways to proceed.

6.1. Application of the Dialogical Model:

The Dialogical Model comprises of one consultation. It is for use in supervision. It may also be useful as a reflexive tool for use in the training process of family therapists [see Rober, 2010].

7.1. The research questions:

Has the project addressed the research questions?

1. In what ways does a Consultation Model influenced by the dialogical theories influence a therapist who is experiencing a stuck phase?
2. What can be learned from this to develop the consultation model?

This project has demonstrated that therapist stuckness can be described as a multi- positioned responsive process that is unique to each therapeutic encounter. Hence, to address this feature of systemic practice requires a consultation process that supports the therapist to observe the multiple components, self-positions and perspectives that form the therapeutic trajectory. The dialogical approach with support from the cognitive field of study supports this reflexive activity.

From a retrospective position, to advance this type of model, it is essential to take a step back and study what systemic therapists think of self-reflexivity. This research activity would entail a number of interconnected themes, namely:

I. Exploring how family therapists negotiate between what they bring to the therapeutic encounter with what the family brings, with what emerges in the intersubjective space.
II. Exploring what reflexive tools they find useful e.g. use of metaphorical drawing [see Rober, 2008c, 2010].

These themes have been explored in the past but continue to pose questions [see Jensen, 2007]. The therapeutic observing-of-self, as positioned within the therapeutic encounter, is a mysterious process that is better understood as a horizon continuum that does not always fall into place [see Stern, 2003]. What can be achieved in systemic practice is the further exploration of how family therapists engage in reflexivity and from that observation, the advancement of understanding, and thus, the advancement of reflexive tools [see Rober, 1999, 2010, 2011].

8.1. Critique of the Dialogical Consultation Model:

<u>What has the project achieved?</u>

The project has looked closely at how best to support a therapist to address a stuck episode. This project has also looked at how systemic therapists reflect. These observations supported the development of a consultation model that could also be used as a self-reflexive tool. However, from a retrospective position, I now see areas that I have neglected. The following discussion will address these points.

What aspects of the model construction have not been highlighted?

The dialogical perspective [see Anderson, 2007b; Rober 2005b] has influenced the model development. However, to return to the opening description of this perspective, the interrelated concepts of participant unity [Gadamer, 1976, 1990/1960], and, polyphonic collectivity [Bakhtin, 1981, 1984, 1986] were described as the key aspects of this approach to practice. The consultation process as directed by the developed Dialogical Consultation Model, did not fully address both concepts. The model format supports the therapist to observe their reflections and how they interact. Therefore, to a certain level, the consultation format addresses the polyphonic concept. However, the model as a process failed to support an interactive dialogue between the consultant and the participant. To place this discussion into context, a consultation process, as directed through a dialogical perspective, can be described as joint exploration of a therapeutic encounter where both parties contribute and engage in a generative dialogue that enriches both the therapists and consultants way of observing the described family story, observing their own self and their-self within-the-therapeutic environment [see Burck, Barratt and Kavner, 2013; Daniel, 2013; Lowe, 2000; Mason, 2013; Rober, 2010; Ungar, 2006]. With reference towards Mason [2013] and this author's description of the process of consultation, as influenced by a postmodern ethos, a consultation process should support a "culture of contribution" [2013, 122].

Thus, on reflection of the key concepts of dialogue[60], and in response to the current descriptions of the consultation process [see Daniel, 2013; Mason, 2013; Rober, 2010], the model provides a reflexive space for the consultant and consultee to observe and witness the therapeutic story or engage in a joint exploration of the therapeutic encounter. A number of the model questions do support dialogical thinking, and thus support joint reflexive activity. However, the format is lengthy, which in practice, reduces the reflexive space.

In response to this theme and as a preliminary exploration, I have looked at the modified model with particular attention towards the horizon style questions i.e. questions that fit with the dialogical perspective [see Gadamer, 1990/1960]:

Example [see Appendix 9]:

Qu. 2: "Describe how the family observe and/or share their story".

Qu. 3: "Describe your journey with this family".

[60] To describe dialogue through the ideas of Bakhtin [1981, 1986], dialogue only happens when each party is coming to the conversation free from the control of the other, or does not try to fuse the other into one-ness.

Qu. 4: "Let us look at the therapeutic process...when you sit with this family what do you observe?" Prompt: "What images do you have in your mind when you hear the family's stories?" [Rober, 1999][61].
Qu. 5: "What is it like to sit with this family and hear their stories?"

In practice, these type of questions support joint reflexive exploration.

Following my reading of Daniel [2013], Mason [2013] and Ungar [2006], and their current description of the consultation process[62], I have put together a number of these reflexive questions and developed a short reflexive tool. This tool provides a reflexive platform that supports the therapist and consultant to observe the family encounter in a way that allows a joint exploration to develop [see Appendix 10]. This model utilises similar wording to that of the developed dialogical model but evokes a different pace, an ebb and flow that provides space to ponder and reflect together. This model departs from the idea of stuckness. It moves the consultation process towards an activity that connects personally with all parties. The reflexive questions can stand alone as reflexive prompts or can be used in collaboration with the other reflexive questions with aim to support a dialogical/Gadamarian hermeneutic reflexive activity.

<u>My role during the course of the project: Researcher versus consultant and colleague:</u>

In correlation with the above theme, during the course of this project, I was confused as regards my role. Was I a researcher or a consultant? Alternatively, could I move between the two roles? I am aware that I was distracted by the research task. This theme did emerge during the course of the consultations but continues to raise questions. From a retrospective position, I now understand that I paid little time engaging with the participants, the stories they were sharing, and, how I as a colleague and person with a unique self-hood could support the exploration of the therapeutic encounter[63].

To address, this theme, I will return to the ideas of Ricoeur [1970]:

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[61] This prompt was added post consultation 6 with the aim to evoke a reflection on the family's story in a manner that gives it depth and generates a curiosity about what has been said and not yet been shared.
[62] A description that defines the consultation process as a dialogic activity.
[63] Rober [2010] explores how to bring the dialogical perspective to supervision. Rober [2010] talks about *staging a dialogue*, a process that brings together the dialogical concepts of polyphony, connectedness and the horizon process [selected highlight].

The consultation interviews were positioned within a research environment. They were overshadowed by my drive to conduct the research task. What do I bring from this observation? If I return to the ideas of Ricoeur [1970], as described by Smith et al [2009], and locate myself within a position of empathy and questioning [see Smith et al, 2009]. The question that arises is how can I re-read my distractions through the eyes of the participants? I can hear the participant's voices again sharing their distressing stories. What was that experience like for them, when, I, as the acting consultant, was distracted? If I place myself in their shoes, I believe, I would have been reluctant to share and explore sensitive themes. This again brings the discussion back to the experiencing-self theme and the participants move between the sharing and non-sharing of experiencing ideas and reflections. What arises from this discussion is that the consultation process is not simply about how effective a reflexive tool is but also about the type of the relationship between the consultant and consultee and what each person brings to that encounter [see Daniel, 2013; Ungar, 2006]. This is an aspect of the consultation process that I did not address at the start of the project.

The question is how do I move this discussion forward? This is a difficult aspect for me to observe. This project has been underscored by my interest in how we accommodate the experiencing–self of the therapist into the self-reflexive and consultation process. I believe the therapeutic observation of the therapist and how they engage with that dimension of therapy is central to family therapy and its future direction of inquiry. However, my role, the position that I adopted and how I connected with the participants to an extent was overlooked as I took part in this research journey. Yes, I did place a lot of emphasis on the prejudices that I brought to this project. I employed a reflexive framework. This process addressed my historical prejudices and how they connected with the emergent themes. However, I did not address my experiencing-self. I did not observe how I felt when I listened to the shared stories and how that listening might have influenced the consultation process. From me as a therapist it raises significant questions about how I understand the idea of connecting. It leaves me with questions about how I move forward as a therapist[64].

This discussion, I suggest, highlights the gap I created between an observation of how I as the researcher connected with the research theme and how I as an active player engaged with the participants and the stories they shared. There is an interconnected link of which I overlooked. This observation resonates with the systems and dialogical theories. It brings

[64] This discussion highlights the gap between research, clinical theory building and the observation of therapy–in-process as a collaborative generative activity.

forward questions about how to bring together within a research milieu, the observation of how the participants engage with the projects theme, with an observation of how the researcher engages with the theme, with an observation of the intersubjective space and the dialogue that emerges within that space. This is a complex process that necessitates a systems perspective. It is a process that is dependent on the intentions and parameters of the research [see Smith, 1994]. Therefore, it is a process that requires pre research planning. This discussion revisits the Action Research versus Participatory Action Research quandary and highlights the pre research-planning phase and more importantly the pre research perspective.

9.1. Closing synopsis:

This chapter defined therapist stuckness and how it can be addressed through a consultation process. The amended model was presented. I believe, this consultation tool reflects the ethos of systemic therapy and how it identifies itself at this phase of its evolution.

In addition, and in response to the critique, a standalone reflexive tool was put forward. It is at its preliminary stage. This tool puts forward a number of linked reflexive questions that aim to support the therapist and consultant to reflect about the therapeutic encounter in a dialogical way. It reflects current descriptions of the consultation process in systemic practice.

The conducting of the project was a challenge for me, the researcher. It introduced a dialogue that I did not expect, a dialogue between what I brought to this project and what emerged during the course of the consultations. Hermans [1999, 2003, 2006] writes dialogue is only possible when there is difference. The final section of this project will look once more at this dialogue and critique.

SECTION C:

An overview of the research trajectory with a closing reflection on how this project may advance systemic understanding of therapist stuckness and the consultation process.

Orientation to Chapters 8-9:

Section C contains 2 Chapters. In Chapter 8, themes that arose from the research process will be further outlined. Finally, in Chapter 9, I will give some thoughts on the research design and how it fitted with the task of the project. I will then share some ideas of how this project may advance.

CHAPTER 8:

DISCUSSIONS ARISING FROM THE RESEARCH PROCESS:

> "The essential nature of the historical spirit consists not in the restoration of the past but in thoughtful mediation with contemporary life".
> Gadamer [1990/1960, 168-169].

1.1. Introduction: A synopsis of the project:

As I reach the closing stages of this project, I raise the question what can this project add to systemic theory and practice?

The project presented a consultation model. The model in practice strives to support the therapist to generate a story that engages with the totality of their involvement with the client group [See Binswanger, 1913: as read by R. Frie, 2009]. It is a reflexive activity that supports the therapist to think about and understand their "selves" and the client group in the context of the therapeutic encounter [see Rober, 1999, 2010, 2011]. Therefore, it is a preparatory reflexive process that addresses all aspects of the therapeutic encounter.

The dialogical perspective underpins the model. What can this approach add to the consultation process? The dialogical approach to consultation brings with it an interest in the uniqueness of the therapist, the uniqueness of the client group and the uniqueness of the inter-subjective space, with an emphasis on the meanings as experienced by both parties without reverting to theoretical preconceptions. Thus, it is a reflexive activity that brings forth the humanness of systemic practice.

This is not a new approach to the systemic consultation process. I believe, it reflects current discussions[65] [see Burck et al, 2013]. Therefore, what does it add? I believe, it adds to the existing approaches by providing a reflexive framework that supports a therapist to connect with all aspects of their encounter with the client group. Thus, it is a challenging process that in practice has the potential to generate new or alternate ways of connecting. This process

[65] I do appreciate that the long version of the model does not fully support a dialogue between the consultant and consulate [see Daniel, 2013]. As discussed, this aspect of the consultation process was overlooked until the closing stages of the project.

supports therapeutic movement. And, in response, diminishes the potential emergence of therapeutic stuckness.

In addition, this project, in response to observing how therapists process stuckness, had the opportunity to observe how systemic therapists reflect in a consultation process. From this study, the therapist's reflexive trajectory can be described as a complex activity with a number of interconnecting reflexive layers. This observation borrows from and advances the ideas of Rober [1999, 2005a, 2008a, 2008c] and Rober et al [2008a, 2008b].

To conclude the opening synopsis:

This chapter started with a synopsis of the project. The ideas developed in this project are not new. The project simply brings together developed ideas in a different way. However, to return to an earlier comment, I believe, each observation and developed reflexive tool provides new ground for clinical discussion with the potential to advance clinical understanding and practice.

The chapter will now continue with a return to a number of the key research themes that emerged.

2.1. Theme 1: The position of prejudice in research:

A revision of the researcher's perspective:

To return to my perspective, I have come full circle. When I started this project, it was led by ideas from the dialogical approach with particular reference towards Andersen [1995] and Rober [1999, 2005a, 2005b]. I am unsure why I shifted towards the cognitive sciences. Order at that time made sense to me. It offered a platform from which I could envisage, and hence, understand the internal dialogue. I do continue to borrow ideas from the cognitive science field[66], although not referenced, do underpin the reflexive trajectory process. In response to the changing perspective, the model moved from understanding the reflexive process of the therapist as an insular activity that is isolated from the third space to a reflexive activity that is positioned within the shared space of the therapeutic encounter. Therefore, it offers a different platform from that of the original, a platform that is dialogic in perspective, a platform that engages with the totality of the therapist's involvement with the client group.

[66] It is difficult to differentiate between the various schools of study in relation to the study of the internal cognitive processes. I have not the expertise to expand on this discussion. However, the general concepts cross over between the various schools.

The change in perspective was driven by the participants input. Their input influenced the model development. However, my prejudice delayed the uptake of the participant's ideas. The Gadamarian hermeneutic reflexive lens did not appear to influence my thinking. The question that arises is how do you fully address prejudices in a research environment?

The position of researcher bias:

As I look back over this project and observe how I sat with my pre research prejudices, I now believe that, yes, I did recognize them but I did not acknowledge their limitations. I did not acknowledge the alternative ways of understanding the internal dialogue and how it fits into the intersubjective space. In addition, I did not explore the process of consultation. I did not look at the bigger picture. I set the parameters. My lens was restricted. In light of how I approached this project, I believe that the researcher needs to recognise and accept the prejudice that they bring to the project, acknowledge the parameters that they set, and then, observe the other horizons. This reflexive activity places attention on the pre research phase.

To add to this discussion, Gadamer [1990/1960] points out that preconceptions are constantly been revised in the process of interpretation. Moreover, that the interpretation of the other is always influenced by our own lens. Therefore, the research trajectory must include a reflexive space that supports the researcher to reflect on the inevitable bias that they bring to the fusion of horizons and reflect on how they have the potential to continue framing the observational parameters.

To bring these reflections together, the reflexive framework must first address the pre research prejudices in a manner that aligns them with the alternative ideas and thus generates a dialogue. Second, the framework must incorporate a reflexive space that prompts an observation and appreciation of all dialogues that emerge during the course of the research, with not necessarily a move towards the creation of an amalgamated understanding, but a move towards an appreciative understanding that allows all dialogues to be heard and challenged, with a shift of observation from the whole to the part and back to the whole. This pathway will allow the research to unfold in a dynamic way [see Smith et al, 2009].

To return to the developed Gadamarian reflexive framework and to advance in terms of use in future research, the framework requires a closer observation of the researcher prejudices at the pre research phase and a more in-depth dialogue between the emergent research dialogues:

Amendments to the Gadamarian Reflexive Format [see Appendix 11]:

Domain one: *To add*: "Am I, as the researcher, open to alternative ways of observing the research themes?"
Domain three: No additions, however marked attention needs to be directed towards "Are both parties open to reflecting on the horizon parameter or bias perspective of the other?" Prompt: "Is a reflexive space provided that supports both parties to engage in a dialogue where they can contribute and acknowledge the otherness? [see Mason, 2013].

3.1. Theme 2: Action Research versus Participatory Action Research: A retrospective observation:

For this project, I endeavoured to generate a research activity that was collaborative and thus emulated the Participatory Action Research [P.A.R.] ethos. However, at the close of this project, I can now identify the unique challenges faced by attempting a P.A.R. approach.
From a retrospective position, my efforts to promote a participatory research activity did not reach the ideal at all times. It was difficult to remain within a collaborative frame of inquiry as I approached the different aspects of the research trajectory and attempted to accommodate the different tasks of the model development. I moved between a tentative collaborative position and an observer/researcher position. Is it possible to conduct a P.A.R. project in a manner that is faithful to its described ethos? As I now understand, to conduct a project through this lens requires substantial pre research planning, a planning process that needs to accommodate all the participants and not just the researchers. Thus, if the opportunity arose to advance this project and in order to achieve a P.A.R. activity, the task would be to sit with all participating parties' pre research and plan the activity together in a co-constructive mode.

4.1. Theme 3:

The position of Phenomenology in this project:

There appears to be a contradiction in the selected approach to this project. As noted, Action Research is interested in the collaborative dialogue. Gadamarian hermeneutics is interested in a reflexive dialogue that arises out of a synthesis of ideas and reflections between the researcher and the research participants. However, Phenomenology, as an observational and analysis lens does not appear to fit.
To justify its inclusion, the Phenomenological lens offered a methodological horizon that provided an observational lens that explored, first, how the participating therapists experience

stuckness, and second, how they engage with the consultation model. This lens brought forth the therapist's individual ideas removed, to some extent, from the research medium and the researcher's prejudices. It provided a space to observe and explore the participant's thoughts. This information supported the construction of the dialogical model.

5.1. Theme 4:
The consultation process: The ethical parameters:

The consultation process can bring to light sensitive reflections of both the client group and the therapist. This raises a number of interlinked questions. First, how suitable is the theme of consultation for research? If research is considered, how are the ethical parameters addressed? Moreover, and to expand on that question, how do you ensure that the developed ethical guidelines warrant that the research process will be a safe and trusting environment for all active and non-active participants[67]?

To bring these questions to this project, this research has looked at the consultation process. How did I address the ethical parameters? At the start of the project, I developed ethical guidelines. I focused on the ethics of consent and confidentiality. Before each consultation, I informed the participants of the ethical parameters that I had developed [see Appendix 1, 2, 3, and 4]. Following this sharing of information, the participants signed the consent form and subsequently met with the identified family group to request permission to include their story. However, from a retrospective position, I am now aware that I overlooked a number of important ethical matters. I defined how to start the project but ignored the research trajectory. How does an ethics perspective support the research process? Ethics speaks of dialogue, transparency and openness. Did I put into place processes to support these aspects of ethics? My response is, no. My attention was on the model and its development, and subsequently, I ignored how the participants were experiencing the research consultation. Thus, how do you bring ethics into the research process? Active, open dialogue, between the researcher and participants supports transparency and maintains an ethical watchtower over the research. As I now look back at the research, I judge, for a project that touches on sensitive material, and to be ethically accurate, it is paramount that the ethical parameters are

[67] For this project, the family and client group.

developed by both the researcher and the participants, and, that the theme of ethics, and all that it entails, is addressed at all phases of a project.
This theme brings our discussions to the research participants and how they experienced the research.

The consultation process: A dialogical orientation:

At the closing stages of this research, I feel that it is important that I revisit how the participating family therapists experienced taking part in the research [see Chapter 7, Section 8.1]. This theme fits with the ethical parameter discussion. It poses questions around how to ensure that participants experience the research activity as a safe, exploratory environment, where a genuine interest in dialogue is present.
To explore this theme, I step back from the research activity and reflect on how I conducted the consultations. I believe my drive to develop a model overshadowed all other aspects of research. I did not pay attention to the participants as active players within the research activity.
How was that for the participants? At the post consultation phase, I requested the participants to reflect on how they experienced the research. In response, the participants reported on the model and not on how they experienced the research. This reply was in response to the question I posed. I did not directly open space to explore the participant's research experiences.
Why did the participants not comment on the research? Firstly, I showed limited interest in this theme. However, and more importantly, to appreciate their response, it is important to outline my relationship with the participants. I reside in Ireland. Currently, there are approximately two hundred registered family therapists in my homeland. Although we may not all be familiar with each other, it is still a small pool of therapists. A small group brings with it loyalty. How will a sense of loyalty translate to the research environment? I believe the participants did not feel that they were in the position to explore or challenge my ideas or the model.
With this research dilemma, what measures could have been taken to reduce the impact of these two concerns. This question will be addressed through two perspectives.

<u>My position as the researcher:</u>

This theme has emerged a number of times. I have highlighted the need to create a research environment where all parties are involved in all aspects of the project, to include the shaping of the research question, research design and research trajectory. A systemic approach from the start of this project may have limited my overt influence over the model development and the participant's hesitancy to challenge ideas.

However, to focus directly at the post consultation feedback, what could I have introduced at that phase of the research to support the participants to engage in an open dialogue. The post consultation questions focused on the model and its effectiveness. To generate a dialogue between the participants and myself it may have been helpful if I looked at how I engaged with the model, and the research process, and introduced these themes into the dialogue. As discussed, a theme that continuously arose was my relationship with the participants. I felt distanced from the family therapists, as a result of the model form. This theme, if introduced into the post consultation phase, may have supported a different conversation. It may have enabled the participants to introduce their own ideas around how to adjust the model in a manner that supports dialogue between the consultant and consultee, and, how to conduct research in a manner that supports openness.

Furthermore, research programmes invite students to engage, connect and contribute to the research community; and, communicate with the academic team and supervisor. This is an area I neglected, due difficulties in getting time off work, no study leave, travel distance and financial reasons. From a retrospective position, it raises questions around how I could have approached distance learning in a way that employs technology to my advantage.

The position of the research participants:

The participants were placed in a difficult position. They were requested to engage in a consultation exercise that required the disclosure and exploration of sensitive themes. Space for shared dialogue was limited, with again my drive to develop the model overshadowing the reflexive dialogue. Moreover, as noted, I believe, loyalty blocked discussions on the research process and the model. To address these issues, I return to the pre-research phase. A systemic approach towards the ethical parameters and processes, and how the model was to be developed and studied, may have prevented some of the obstacles emerging. A Participatory Action Research methodology may have been a more suitable approach.

I have focused on the research process and looked at ways that may have brought about a more dialogical environment. However, to conclude the ethical discussion, it is necessary to look at the developed model and its style, and question how that influenced the

communication patterns in this research. On reflection, the model leaves limited room for a reflexive dialogue [see Appendix 9]. The task of the model was to support the therapist to generate a holistic story of the therapeutic encounter. The attention was not on the relationship with the consultant or on developing a reflexive dialogue. In response to this concern, how could I adjust the model in order to support reflexive dialogue? As the project proceeded, I began to notice the distance between the participants and myself and the limited space for reflexive dialogue. In response, I developed a short reflexive tool [see Appendix 10]. This reflexive tool draws from some of the later research ideas and brings together dialogue with relational hermeneutics. The reflexive tool, I judge, is more reflective of contemporary consultation ideas that highlight the position of a co-created reflexive dialogue within the consultation process [see Burck et al, 2013]. To bring this research forward, I believe the final draft of the dialogical model [see Appendix 9] is useful for trainee family therapists as a reflexive tool in preparation for supervision. It supports the therapist to be curious about the family story. The short reflexive tool supports reflexive dialogue. Thus, in order to advance this project my interest is not on adjusting the dialogical model but on further advancing the short reflexive tool.

The task of the model, and subsequently, its style, did not fully fit with the research approach. These tensions were not fully explored during the course of the project. This dilemma highlights the difficulties that can arise when conducting clinical studies. I believe the observation of clinical practice and the introduction of new ways of practice is complex and difficult to address in a genuine systemic manner within a research environment. A tensional field can arise between attempting to observe practice, attempting to introduce new models, and simultaneously ensuring an open, transparent environment at all phases. This process calls on a systemic perspective within the research process [see Flood, 2006], and on a commitment to connect with the research community in order to keep the research focus open to alternative ways of observing the theme.

6.1. Conclusion:

This chapter has highlighted themes that arose in response to the research aspect of the project. The chapter illustrated the continuous struggle that I as the researcher experienced as I attempted to balance what I brought to the project with the ideas of the participants. This discussion highlights the complex environment of research and the complex relationship between the researcher and the research participants.

The project has brought forth many questions for me, as a therapist. It has challenged the way I observe prejudices and how I position myself in the therapeutic environment.

The final chapter will direct its gaze to the future. First, it will look at how to advance this project. The chapter will then look at alternative research projects that could support this project. Finally, the chapter will conclude with a look at what I bring from this project.

CHAPTER 9:

FURTHER RESEARCH AND A CONCLUSION TO THE PROJECT:

"We shrink back from the great mass as they shrink back...."
Heidegger [1962/1927, 164].

1.1. Introduction:

The objective of this project was to define therapist stuckness and from that information develop a reflexive tool that could support a therapist when they encounter this phenomenon in practice. A description was put forward. A pilot dialogical consultation model was introduced, amended in response to the participant's engagement with the model, with a final draft presented. In response to the critique, a short version of the model was developed. Both versions are for use in consultation and for training purposes.
This chapter will look at how to build on the reflexive model. It will also identify parallel areas of interest that could be addressed by research. The chapter will close with a reflection on how the project influenced me, as a practicing family therapist.
To take a step back, this chapter will open with a look at how the participating family therapists observed the model in practice. This opening discussion is included in order to bring this project to its concluding horizon.

2.1. Is the consultation model helpful?

Is it possible to translate the therapeutic encounter and all its intricacies to the world of consultation? This question was posed at the start of this project. In order to respond to this question, I would like to return to the participant's thoughts on the model and look at some of their reflections as regards self-reflexivity and how the model supports that process. This discussion will then proceed with a reflection on how I view the model at the close of the project.

First, the participants views and with that I will revisit Elizabeth's story.
Elizabeth commenced the post consultation conversation with a look at how the model supported her to step back from the stuck thinking and move towards a broader description.

This broader description supported her to reflect again on themes that otherwise had been overlooked:

Elizabeth: Post Consultation review:

Line 1-5: "I found the meeting very helpful and useful in broadening out the story and moving from the stuck phase that we had being in when me and the family talked over the same things again and again …our conversations shifted back to towards discussing relationships and interactions in the family".

Interestingly, Elizabeth then shared the idea that this moving towards a broader description re-energized her and from that position, supported her to explore themes that are more meaningful with the family:

Elizabeth: Post Consultation review:

Line 88-87: "My thoughts and ideas were re-energized which had an impact on the dialogue through my questions considering the mothers role as a mother and her thoughts that she had failed her children and her husband in her earlier life".

The introduction of this theme by Elizabeth illustrates, I believe, a closer connection with the family. It is difficult to know fully if Elizabeth's engagement with the model supported this connection. However, at the close of Elizabeth's post consultation meeting she shared that the model "supports a shift in focus …a shift towards the sharing of experiences" [Line 107]. This idea reflects the empathic observations and reflections phase that we touched at an earlier stage of the analysis.

To continue this theme I will look at Michael's story.

Michael shared that his engagement with the model brought him to a different position. The model supported Michael to metaphorically stop, and listen to the client. He shared "and you know I actually found myself not saying a whole lot, but she just told me her story" [post consultation: 34-37]. This slowing down process supported Michael to reconnect with the client. This process brought in new thoughts and emotions for Michael. He shared that he felt "encouraged, renewed and reflective" [P.S. 4].

How did these emotions and feelings translate to the therapeutic encounter? Michael spoke of how the model supported him to take a meta-observational position and from that position

observe the client's story, how he connects with the client's story and how that connection can enhance the therapeutic encounter:

Post consultation: Line 290-296:

"It helped me to take a step back and to actually really listen to what is going on because quite often I get into a rhythm of my own life and relationships...And my children….and just to listen and allow her the space to be just herself".

In continuation,

Post consultation review: Line 400-411:

"I'm not too sure how to say it… [pause]… but it's like I had a new eye and the thing is about listening, it is the same conversation that we had the last time but it is different in that for me because I was listening differently, listening differently in that I was more attentive …allowing the conversation to happen in the moment …and just to sit with the terrible sadness and loneliness of this woman and that kind of resonates with me".

I am not too sure if I have built up a strong enough argument. Let me bring together what the participants are reporting. The above extracts illustrates how the participants, as prompted by their engagement with the model, stepped back from their day-to-day practices, and revisited their experiencing-self, as triggered by the therapeutic encounter. This observation triggered a self-reflexive trajectory that they reported supported a positive shift in the therapeutic dialogue.

Thus, from the discussion it would appear that the model is helpful. Therefore, yes, it is possible to translate the therapeutic experience to the consultation process. The model in practice strives to bring to life the therapeutic encounter. It strives to give meaning to the encounter and to the stuck episode in the world in which it is formed. Each consultation demonstrated this process.

The model over the course of the project evolved with the aim to further support the therapist to engage in a self-reflexive dialogue. However, this process is dependent on the therapists approach to reflexivity, and, dependent as discussed, on the connection between the consultant and the consultee, and how the reflexive tool supports this process. I have commented on this theme.

However, to end this opening discussion, let us revisit my prejudices. I believe, therapist's self-reflexivity, is central to effective systemic practice. In addition, I believe, therapist self-reflexivity, which incorporates the different stages of reflexivity, is only effective when it is

conducted through a trajectory that commences with an observation of how the therapist connects with the client group [see Rober, 1999]. These prejudices directed me, as the researcher to observe the generated data in a certain way. I ignored other aspects of the stories shared by the participants. To illustrate, I will return to Kathleen's consultation. Kathleen spoke of her historical-self and how an observation of this self-hood, as in response to the stories shared by the client group, supported her to connect with the client group in a supportive way. However, the therapeutic encounter continued to be directed by the overarching professional parameters with Kathleen sharing that the therapeutic process moved towards the child protection sphere of practice. Therefore, as cited by Elizabeth, many of the families that we have the privilege of meeting, bring with them a clinical description of which we cannot ignore. This raises a different question that I have not addressed in this thesis. Moreover, this theme questions how useful is the developed consultation model in a therapeutic meetings where child protection is a key theme.

To close this discussion on a more positive note, Elizabeth defines the model in a way that allows it to accommodate to some extent the above discussion:

Elizabeth Post Consultation: Line 108-112:

> "The dialogical model is a model that is helpful in offering a guide to considering our interactions and conversations with our clients in that it encourages us to focus on what's emerging in the dialogue between you and the client and how our questions are informed by this flow which can promote new ways of thinking and talking about aspects of our lives which we consider to be problematic, limiting or negative".

This chapter opened with an overarching observation of the model. I will now direct my gaze to the future and look at how this project may advance.

2.1. Implications for research:

Further development of the Dialogical Consultation Model:

Slavi, Greenberg and Stiles [2006] discussed the process of theory building and suggest that its development should be permeable and should constructively evolve through "the infusion of new observations and observations made by the research participants while respecting previous observations" [2006, 165].

The same principal applies to the development of the model. In terms of the research continuum, the model development is at an early stage. The model has undergone its first phase of development. I have reviewed how the first phase was conducted. In response, I believe, in order to advance the model, a research group forum, as directed through a Participant Action Research lens, would be helpful [see Reason and Bradbury, 2006]. Participant Action Research, as a research approach, promotes a research dialogue where all participants are equal and where the researchers/observers position becomes subsumed into the co-created dialogue [see Flood, 2006].

This research approach has a number of interconnected advantages. First, a group forum creates a research environment that challenges prejudices, a factor that has emerged at the first phase of this project. Second, a group forum supports an environment where the intersubjective space is central thus addressing the reflexive gap that I identified.

The chapter opened with an overview of the model. I put forward a suggestion on how to advance this approach to the consultation process. I will now continue with a look at linked and alternative areas for research:

3.1. Areas for further research:

Further research on parallel connections:

Through this research, I have focused on therapist's self-reflexivity within the consultation process. Reflexivity as a process has undergone multiple of revisions in response to the changing perspective of systemic practice [see Andersen, 1995; Burnham, 2005; Jenson, 2007; Lowe, 2000; Rober, 1999, 2010, 2011]. To advance this theme, there are a number of questions, which if addressed through a research forum, will broaden the understanding of reflexivity, as it is currently understood by family therapists[68] [see Mason, 2010]. This information will assist in further advancing the understanding of reflexivity as it is practiced, and thus, support the further advancement of reflexive tools, and in link, the development of the dialogical model:

Research questions exploring how therapists describe self-reflexivity:

[68] The description that I put forward is based on a literature review and as an outcome of this study. A phenomenological study of reflexive processes and trajectory in systemic practice would add to this study and other related studies [see Jenson, 2007; Rober et al, 2008a, 2008b].

1. How can we now describe self-reflexivity in systemic practice?

Research questions exploring the process of self-reflexivity in systemic practice:

2. How do systemic therapists observe how they position themselves in the therapeutic encounter?
3. What type of reflexive tools or activities do systemic therapists find helpful [see Andolfi, 1984; Rober, 1999, 2010, 2011].

Comparative studies:

Comparative studies, I believe, challenge ideas and practices. I judge that it would be interesting to study how therapists from the systemic field describe and practice self-reflexivity in comparison to therapists who practice in alternative fields of therapy.

Alternative research questions:

All research projects are driven by the preset research questions. These questions determine what aspects of the study are to be examined [see Willig, 2011]. Other dimensions of the theme are overlooked.

The same can be said about this project. I had the privilege to meet with family therapists and hear their stories and the stories of the families they meet. I focused on how to address stuckness from the therapist's perspective. Many interesting themes were disregarded. One aspect that I found interesting is how family therapists share the story of the family group. The story is weaved together in a manner that brings together all the characters, themes and emotions with an overarching search for new ways of going forward. And, if supported i.e. if the consultation process poses reflexive questions that support the therapist to observe how they position themselves within the therapeutic encounter, the therapist's own story then becomes weaved into the family's story. If I were to revisit the collected data, I would like to explore this theme. As a research theme, it can act as a standalone research project that looks at the process of storytelling as positioned within systemic practice. As an adjoining study to this completed project, the outcome will have the potential to advance the model development.

Research questions exploring how family therapists tell the family's story:

1. How do family therapists share the client group/family's story in a consultation process[69]?
2. How do family therapists share the original meaning of the family's story, and what prompts this story to evolve[70]?
3. What prompts the family therapist to weave their story into the story of the therapeutic encounter?

I have looked at how to add and advance this project. I will move the discussion from the research lens to a more personal lens.

4.1. How the project influenced me, as a practicing family therapist:

I have looked at the impasse discussions outside of the systemic forum [Mellor, 1980; Petriglier, 2007; Petriglier and Wood, 2003]. These discussions suggest that an impasse might present opportunities for developing new understandings of the self [of the therapist], and thus, be of therapeutic value. Bion [1961] suggests that an impasse can be a useful catalyst for curiosity, which can lead in turn to beneficial insight.

This project has challenged me. The project became a study of myself. It posed questions about how I accommodate otherness and difference. To take a step back, I approached the study with ideas about how cognitive ideas could be incorporated into the model with the aim to change the therapist's thinking patterns rather than promote openness and curiosity. At the start of the project, I was not open to how the therapists were engaging with the model. I was distracted by the research task. Thus, the project demonstrates the sway of prejudices. Gadamer [1990/1960], talks about how "our history is not something that lies behind us as objective facts, but rather that which guides and leads our understanding" [1990/1960, 172].

This discussion brings to the fore the title of this project. What is the potential therapeutic value of therapist stuckness? To answer this question, I will observe how I responded to the research. Over the course of this project, I have looked at my reluctance to step outside of my prejudice. I was stuck in one position. The project challenged my prejudice. It supported me

[69] Themes: What positions do the therapists speak from e.g. professional, systemic, advocate or opponent? What voice leads the description? How does the position of the therapists influence the storytelling process or trajectory? What aspects of the family story are seen as important or what aspects are ignored? How are the various family voices incorporated into the story telling process and trajectory [see Rober, 1999, 2008a, 2008c]?

[70] Themes: What supports the family therapist to observe how the family's story prompts or connects with their own unique story? How does an observation of the therapist's story support the family's story?

to step outside of my understanding and observe from alternative positions. Thus, the value of my stuckness is that it moved me from an unchanging observer's position to a position where I was challenging myself. Through the process of challenging myself, I not only stepped into understanding myself that little bit more, but with this new self-curiosity, it opened other doors of inquiry. What is interesting about this discussion is that I highlight the shift from a dominant prejudice position to a curious position. For me, what instigated this shift? To answer that question from a self-reflexive position, I now believe that I allowed my voice to do all the talking. I gave no room for other voices. When I quietened my voice, other interesting voices arose and offered alternative ways of observing the theme. How did I quieten my voice? Simply by taking time out, time away from the project, and from the stress of completing the research.

Thus, to return to systemic practice and in response to the outcome of the consultations, the potential value of therapist stuckness, is its capacity to prompt the therapist to be more curious about their self-hood. This reflexive activity has the potential to support the therapist to develop a deeper experiencing level, and thus, a move towards an enhanced realisation of how they position themselves within the therapeutic environment.

An interesting question that accompanies this final discussion is how do family therapists know when they are therapeutically stuck. In order to answer that question, I will return to the research participants. Each participant spoke of engaging in a therapeutic process that continuously repeated the same themes without any sense of a meaningful exploration-taking place. The participants identified this activity as a stuck phase in family therapy. How can the therapist hold the dominant idea, at the same time seek, and be curious about alternative ways of observing and connecting? Alternative perspectives are not always readily observable from the therapist's position. As Gadamer noted, we are guided by our history [Gadamer, 1990/1960]. This project has highlighted that time away from the process [i.e. the research or therapeutic process], and reflection, supports a curiosity about the prejudice. Through this curious position, the author becomes aware of the influence of the prejudice, and thus, creates a curiosity about alternative ways of moving forward. Therefore, to conclude this discussion, how useful is the dialogical model and the developed short reflexive tool. Although they may not fully support a dialogical conversation, they draw attention towards the dominant ideas or prejudices, support alternative reflections and thus create dialogical openings.

5.1. A closing reflection on the key theoretical influences:

The cognitive lens versus the dialogical lens:

The idea of the internal dialogue underlined this project. At the start of the project, I utilised ideas from the cognitive field of study with a clear emphasis on the composition and trajectory of the internal dialogue. From a retrospective position, I now believe, that I channeled my discussions into a narrow view of the cognitive descriptions. The emergent ideas within this field reach beyond individualism, representational structures and deductive descriptions, and talk about a more oscillatory type of reflexive activity rather than computational procedures [Ibanez and Cosmelli, 2008]. Again, I reflect on my earlier ideas, and I wonder how they may have supported the final discussions in this project; discussions that brought forward the dialogical approach within the consultation process, and its emphasis on the intersubjective space [see Rober, 2005b]. I now feel that my initial emphasis on the narrow descriptions of the internal dialogue placed me in a reflexive position that was, at first blind to other descriptions, but because of its extreme focus, directed me to metaphorically, turn around, and seek other descriptions that supported movement in the research.

Thus, bias can promote pluralism in observation. To support that claim, a bias places the author in a position that is fixed, with limited ways of moving forward, in a creative sense. The researcher becomes more entrenched in the bias perspective. Two courses of action arise. One, continue with the bias and seek further evidence to support the claim. Alternatively, seek dissimilar perspectives with the aim to strengthen the bias perspective, which, subsequently, supports diversity. I choose to seek an alternative description, as prompted by the research participants. This supported a shift in the project.

Throughout this project, I have viewed the position of prejudices in research, as a negative factor. As overviewed, prejudice can support a shift towards other ways of observing. Thus, if challenged, it can be understood as a positive factor in research.

To close this discussion, it is important that I touch on my descriptions of the dialogical and cognitive theories. According to my descriptions, there appears to be a tension between the two fields of study. This can be attributed to their original focus. The cognitive field has its roots in science and is interested in how people think [Ibanez, 2007a]. The dialogical school of thought has its roots in relational hermeneutics and is interested in observing dialogue [Hermans, 2008]. This school proposes that dialogue can be understood as a multi-positioned,

generational process, where the intersubjective space is central, a space where the emergence of meaning arises [Hermans, 2003].

However, if I look closer at the more recent descriptions, there appears to be a move towards a communion of ideas rather than divergent ideas [Stiles, 2007a]. Both fields discuss the idea of a thought or reflection, as arising from a complex interaction between aspects of the-self [the historical-self, the emergent-self and the social-self], as prompted by the self-in-the-environment i.e. the dialogical-self [Rober, 1999]. Therefore, the schools of thought are moving closer with a joint interest in meaning-making, as a product of social dialogue. Hence, the differences between these schools of thought are now more subtle. The differences are now, not necessarily in how they study the mind and its processes, but rather in, how they use their findings [see Hermans, 2008b; Stiles et al, 1990]. The cognitive field use their findings to advance the understanding of how we think, or in cognitive terms, how we can understand the self-thought organisation process with an advancing interest in the positioning of the social-self, and its influence on the meaning making process [Ibanez, 2007a]. The dialogical field looks at both the internal dialogue and the external dialogue and employs this knowledge as a therapeutic resource [Rober, 1999, 2005b].

To close this discussion, I will not draw on the differences but rather on the connections. Both areas study the mind. Both contribute to a growing understanding of the emergence of meaning beyond individualism. Therefore, I put forward that their connection, and how they can advance each other's ideas, is central. This thought, would have been constructive at the start of this project. It may have supported a flexible approach to the opening phases of the model.

Did my definition of the dialogical approach to practice change?

As this project ends, it is interesting to observe how my understanding of the dialogical approach has changed.

To place this final discussion into context, let us look at how we can describe this perspective? The dialogical perspective as a whole reads as a complex composition of theories and ideas, all arising from a number of different fields of study [see Anderson, 2007b; Bakhtin, 1981, 1984, 1986; Bertrando, 2007; Gadamer, 1990/1960; Rober, 1999, 2005a, 2005b, 2010, 2011; Shotter, 2000]. The Dialogical perspective, I believe, is difficult to understand, and thus difficult to accurately translate to practice, as I have witnessed, during the course of this project.

The question that arises is how did I initially attempt to understand the Dialogical perspective? Originally, in an attempt to understand this approach, I broke it down into small blocks of ideas or concepts. At that time, it appeared to be a constructive way of understanding. This learning process allowed me to understand the perspective in a developmental form. However, from a retrospective position, I now see that I understood the separate theories, but from an understanding position that was disconnected from the whole perspective, i.e. I was reading it from a part perspective.

My original understanding influenced the first draft of the model. I focused on the internal dialogue concept. I ignored the other central aspects of this perspective; namely, dialogue as a generative co-created process, otherness, the intersubjective space, and, the concept of horizons interlinked with the idea of infinalizability [see Anderson, 2007b; Bakhtin, 1981, 1984, 1986; Gadamer, 1990/1960; Rober, 2005b; Sheehan, 1999].

In order for me to take the next step in the learning process, it required a re-reading of the dialogical theories. In addition, it required an observation of how the theories and concepts translate to practice as a whole and not as isolated concepts.

To move this discussion forward, the final draft of the model attempts to reflect the full ethos of the dialogical perspective. This learning process has been an interesting trajectory. It highlights the complexity of learning and the process of translating learning to practice.

5.1. Did my definition of stuckness change?

In response to my evolving understanding of the dialogical approach, my description of therapist stuckness altered. The description moved from a technical description to a description that fits with the dialogical approach. Stuckness, from this project can now be understood as a unique encounter that arises from a responsive, dynamically evolving system that is dependent on the uniqueness of the family system, the uniqueness of the therapist and the subsequent uniqueness of the intersubjective space.

This description, within the therapeutic environment, invites multiple of perspectives and observations to arise and thus invites alternative or new ways of observing the therapeutic encounter. In addition, and on reflection of the ideas that support the dialogical perspective, this description brings to the therapeutic encounter a process that invites renewed ways of observing the client group and how the therapist responds to the therapeutic encounter. Thus, stuckness as a feature of practice can be understood as a vehicle of learning for both the

therapeutic encounter and for the therapist as a unique person positioned within the human activity of systemic practice.

6.1. Dissemination of the outcome of this study:

This study commenced with one idea. As it progressed, multiple of themes emerged, some I addressed. At this stage, my interest lies with three interconnected areas.

First, I am interested in the process of reflexivity in research. I developed a reflexive framework as guided by the ideas of Gadamer [1990/1960]. I plan to further develop this framework and subsequently develop a paper for publication.

Second, the conducting of this project provided me with the opportunity to observe how family therapists think during the course of a consultation process. The theoretical and clinical ideas of Rober [1999, 2010, 2011] and Rober et al [2008a, 2008b] supported this observation. I am interested in further developing these observations with again the aim to develop a paper for publication.

Finally, the overarching aim of this project was to observe stuckness in systemic practice and in response develop a consultation model. I do hope that I will have the opportunity to further develop this model through a group forum and from that develop a paper for publication.

7.1. Conclusion:

This chapter completes this project. Theory, at first guided this research. Gradually, the participant's voice emerged as the most constructive guide. This shift produced a move from observing the reflexive process as a mechanical procedure to an activity that is dynamic and stimulated by the dialogic-other and the intersubjective space. This information supported the development of a consultation model that I now believe fits with systemic practice.

As a closing note, I thank you for reading this project and I hope it has created some new horizons for you to explore.

For me, it has been a shifting trajectory with many bumps on the road. If I were to bring one reflection from this project, I would settle with one thought that is not necessarily new or remarkable. The thought that I bring, is that systemic practice, with all its theories, and influences, continues to be a human endeavor where the connection between the therapist and family, and all that it brings, is central.

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APPENDICES:

Appendix 1:

Letter to Family Therapy Association of Ireland:

Child and Adolescent Psychiatry Department,
Midland Regional Hospital.
HSE,
Mullingar.
Co. Westmeath.
044-9394219/086-1011363.

Chairperson,
Family Therapy Association of Ireland [F.T.A.I.],
Shankill,
Dublin,
Ireland.

April 2011

Dear Chairperson,

I am about to commence a research project in Systemic Family Psychotherapy. The research project is part of a Doctorate programme in Systemic Psychotherapy. I will be completing the project at the Tavistock and Portman NHS Foundation Trust in affiliation with University of East London, School of Humanities and Social Sciences Department.

I plan to explore the concept of impasse in systemic practice. A number of recent papers have examined the impasse phenomena and in general suggest technical strategies that will assist the therapist to overcome a stuck phase. The purpose of my research is to look closer at impasse and explore one aspect of this phenomena i.e. therapist stuckness. I will introduce a consultative model influenced by the dialogical theories to the research participants with the aim to investigate how a stuck phase responds to a dialogical approach. The dialogical perspective is relatively new to systemic practice and to date no research has been conducted to examine this therapeutic lens or how it may be of value to the processing of therapist stuckness. In light of this, I believe that it is now an appropriate time to study these complex features of contemporary systemic psychotherapy.

The research will entail the recruitment of Family Therapists for their participation in this project. For that reason, I wish to seek ethical approval from the association's management board. In addition, I wish to request permission from the F.T.A.I. board of management to access the member's data-base to forward the projects information leaflets to all members of your organisation with the purpose to recruit participants for this research study.

Each recruited participant will be requested to attend one individual consultation, which will follow a semi-structured consultation format. The consultation will entail the therapists describing a period in therapy when they felt therapeutically stuck and it will be explored through a dialogical consultation framework. Each consultation will be approximately one hour in length and will be conducted at the participants own clinical setting or place of

choice. With their permission, the consultation will be audio taped, to allow for further evaluation after the conclusion of the consultation. The participants will then be requested to meet with the client group and share developed ideas or reflections. The participants will also be requested to meet with me post consultation and post family meeting to explore how the model influenced the stuck episode. The data collected will be used exclusively for the completion of this research project. Confidentiality will be maintained at all stages of the research. Informed Consent will be sought from both the research participant and the client group that they wish to identify.

Please find enclosed the Information Leaflet for your attention. I plan to forward this leaflet to clinicians as sourced on your database. If any further information is required, please do not hesitate to contact me at the above address or telephone numbers attached.

Looking forward to hearing from you.

Thank you for your time and awaiting your reply,

Kind Regards,

_____

Geraldine Richardson, Doctorate Student.

Appendix 2:

Plain Language Information Leaflet:

The Potential Therapeutic Value of Therapist Stuckness in Systemic Therapy:
A Qualitative Research Study:

An Innovative qualitative research project is being undertaken by Geraldine Richardson, M.Sc. Systemic Psychotherapy, as a component of a Doctorate in Systemic Psychotherapy programme. The project will be conducted under the supervision of Dr. Charlotte Burck PhD, at the Tavistock and Portman NHS Foundation Trust, and in partnership with University of East London School of Humanities and Social Studies. The title of the research is: The Potential Therapeutic Value of Therapist Stuckness in Systemic Therapy. This research project will endeavour to explore one aspect of the impasse phenomena, therapist stuckness. Participants will be requested to explore a stuck experience through a consultation model that is influenced by the dialogical-self theories. The aim of the project is to investigate if a consultation model influenced by the dialogical theories is helpful in a stuck phase.

We would like to invite you to participate in this innovative research project. If you take the opportunity to participate you will be invited to attend two individual meetings at your convenience. The first meeting will focus on you the therapist describing a stuck phase that you are currently encountering with a client group. The stuck experience will be explored through a dialogical framed consultation. You will be requested to meet with the identified client group that you are experiencing the stuck phase with after consultation one. The aim of this stage is to offer you the opportunity to introduce to the client group ideas or new strands of inquiry that you may have developed in the first consultation. The second meeting will be conducted after you have met with the client group that you have presented with the aim to explore if the dialogical consultation was of value to the therapeutic process.

The consultation will be jointly arranged on receipt of consent. They will be audiotaped for accurate data collection. Your participation is voluntary so whether you decide to take part or not, it will not affect your rights. The interview process is fully confidential therefore, names and dates will not be recorded, and a pseudo name will be allocated to your consultation verbatim. All data will be stored in a locked filing cabinet. Details of the client group that you may include during the course of the interviews will be omitted. Any distinctive stories of the client group that you include and of which you feel may identify the client group will also be

omitted. You may withdraw at any time, and withdraw any unprocessed data if you wish. Extracts from your interview may be incorporated into the research write up and /or be published. All data generated will be destroyed after 12 months. All participants will have full access to completed findings from the Tavistock Library and can view published results in systemic and related journals.

This research has obtained full ethical approval from the Tavistock and Portman NHS Foundation Trust, and the University of East London School of Humanities and Social Studies Ethics Board and approval has been obtained from the F.T.A.I to access the association's database.

This research aims to help us gain further insight into the impasse phenomena and how it responds to a dialogical approach, a concept that has received no research attention to date. By taking part, you will be contributing to a valuable and growing knowledge base.

Would you like to take part? You may start by contacting me by telephone or email:

Mobile Number: 086-1011363

Email Address: gerildinerichardson@gmail.com

Alternatively, by forwarding the attached form to:

Geraldine Richardson, Child and Adolescent Psychiatry Department, Mullingar Regional Hospital, Co. Westmeath.

I _____[Signature and Block Letters] am interested in participating in the research project which is being conducted by Geraldine Richardson, Doctorate Student, Tavistock and Portman Clinic, under the supervision of Dr. C. Burck.

I can be contacted at:

Contact number_____

Or

Email address: _____

Please see attached stamp addressed envelope.

Appendix 3:

Informed Consent Form: Research Participants [Family Therapists]:

The Potential Therapeutic Value of Therapist Stuckness in Systemic Therapy:
A Qualitative Research Study:

I agree to participate in the research project, which is being conducted by Geraldine Richardson, Doctorate Student, the Tavistock and Portman NHS Foundation Trust in affiliation with University of East London, School of Humanities and Social Sciences Department under the supervision of Dr. C. Burck.

I understand that the research will involve two audiotaped interviews; that participation is voluntary; that the data generated will be fully confidential, and that I may withdraw at any stage of the process.

I understand that the interviews will entail an exploratory discussion on a stuck phase that I am encountering and will entail sharing details of a family that I meet with on a therapeutic basis.

I understand that I will have to discuss with the client group the research, its aim and what participating will entail prior to the project. The client group will be offered the opportunity to participate or not. Informed Consent Form to be completed by client group.

Procedures:

Each participant will attend two individual interviews, approximately one hour in duration. Place of interview to adhere to the preference of the participant:

Dates suitable for interview:

Interview to be held at participant's clinical setting:

Interview to be held at place of choice**:**

I, _____, have voluntarily agreed to participate in the above research project , to be conducted by .....Taking part in this study is my decision and I am aware that I can withdraw at any stage. I understand the aims, the purpose, the procedures and the potential benefits of this project. I am aware that I can contact the Researcher, Geraldine Richardson at any stage to clarify any concerns. I am aware that all information

regarding myself, my part in this study and the identified client group adheres to Ethical and Confidentiality guidelines.

Participant – please complete the following (Circle Yes or No for each question)

Have you read or had read to you the Information Leaflet Yes/No

Do you understand the information provided? Yes/No

Have you had an opportunity to ask questions and discuss this study? Yes/No

Have you received satisfactory answers to all your questions? Yes/No

Are you aware that your interview will be audio taped? Yes/No

Are you aware that the write up of this project will include verbatim i.e. exact quotes from your interview?
Yes/No

Are you aware that the findings will be published? Yes/No

I have read and understood the information provided and I consent to partake in this research project.

Signature:

Date:

Witness:

Appendix 4:

Combined Information and Informed Consent Form: Client Group:

The Potential Therapeutic Value of Therapist Stuckness in Systemic Therapy:
A Qualitative Research Study:

Family Therapy is about connecting with your therapist to talk about issues that are important to you and your family. It can be a rewarding process. However, at times it can become stuck. When this happens you and your family therapist may find it difficult to find ways to move forward.

The aim of this study is to look at times in family therapy when we become stuck. We aim to explore the stuck feeling through a process of consultation. The consultation approach that we will be using will look closely at how we connect with others. We call this the dialogical approach.

To participate in this project it will entail:

Your family therapist will first meet with the researcher to explore the stuck phase that they are encountering when meeting with you and/or your family.

Your therapist will then arrange to meet with you.

Your therapist will explore with you the stuck phase and reflect on the ideas that emerged in their first meeting with the researcher.

The family therapist will then meet with the researcher to explore the family meeting.

The researcher will look at each therapist/ client group interview and investigate if the consultation model was of value to your therapy and if it helped the therapeutic process to find new ways of moving forward.

If you agree to participate, please complete the following:

I, _____, have voluntarily agreed to participate in the above research project, to be conducted by Geraldine Richardson, Doctorate Student in Family Therapy. Taking part in this study is my decision and I am aware that I can withdraw at any stage. I understand the aims, the purpose, the procedures and the potential benefits of this project. I am aware that I can contact the Researcher, Geraldine Richardson @ 086 1011363 or gerildinerichardson@gmail.com at any stage to clarify any concerns. I am aware that all information regarding my family and myself will adhere to Ethical and Confidentiality guidelines.

Participant – please complete the following (Circle Yes or No for each question)

Have you read or had read to you the combined Information Leaflet and consent form: Yes/No

Do you understand the information provided? Yes/No

Have you had an opportunity to ask questions and discuss this study? Yes/No

Have you received satisfactory answers to all your questions? Yes/No

Do you understand that you will meet with your therapist as part of your normal therapeutic plan to explore the stuck phase and that the session will be guided by the dialogical perspective? Yes/No

Do you understand that your therapist will explore with the researcher the stuck phase that developed in your therapy, and how it responded to an alternative consultation model? Yes/No

Are you aware that the findings of the research will be published? Yes/No

I have read and understood the information provided and I consent to partake in this research project.

Signature:

Date:

Witness:

Appendix 5:

Cyclical Framework: Sequence of steps to research framed by Action Research methodology:

Reflexive Step 1:	Task: Researcher to observe the current theoretical and practice descriptions of therapist stuckness and how it is processed in practice. For this project, a literature review was undertaken. On identifying authors who examined the concepts of stuckness and how it is processed, their remaining academic papers were reviewed in order to study their continuum of ideas and how they evolved in relation to therapist stuckness and self-reflexive ideas. This information provided a baseline understanding.
Reflexive Step 2:	Task: I, the researcher, observed my own existing practices. I observed my own practices in the context of the ideas that the literature had suggested. I looked at how I process stuckness. I posed this question: How would it be possible to add or advance my current practice in light of the literature review? Rober's [1999; 2005b, 2010, 2011] interest in the complex composition of the therapists internal dialogue in response to a therapeutic encounter caught my attention. This idea prompted the development of the dialogical model.
Action Step 1:	Task: Researcher to initiate the development of the Dialogical Consultation Model. In light of the literature with emphasis towards the dialogical approach and the current description of the therapeutic–use-of-therapist, the development of the Dialogical Consultation Model commenced. Draft one of model was completed.
Action Step 2:	Task: Pilot consultation. A pilot interview was conducted with draft 1 of the model. I, the researcher participated in the pilot interview [see Appendix 8].

Reflexive Step 3:	Task: Review of pilot consultation. The pilot interview was reflected on. Attention was directed towards the format, how it addressed stuckness and the outcome. In response, modifications to the format were conducted [see Appendix 8].
Action Step 3:	Task: Recruitment of Participants. The recruitment process entailed contacting practicing family therapists, informing them of the project and requesting their participation.
Action Step 4:	Task: Data collection: The consultation trajectory. Each participant was requested to participate in one consultation interview and then to meet with the identified client group to introduce any ideas that may have developed in the consultation.
Reflexive Step 4:	Task: Participants review. Each participant was then requested to participate in a post consultation/ post client group meeting review in order to reflect over their experience of engaging with the model and how it influenced the family session.
Reflexive Step 5:	Task: Reflection on consultation one. On the completion of consultation one, the researcher reflects on the consultation, the post consultation and the post client group meeting review. From that, the researcher reflects on the usefulness of model by bringing together the participants ideas with their own [researchers] ideas and reflections and subsequently revises the model format. An interpretative phenomenological analysis and a dialogical observation support the analysis of the generated data.

	On the completion of each consultation, a feedback mechanism is employed. This feedback process establishes if changes are required to: How the model is presented to the participants. The model layout and the question style. How the researcher engages in the process. In addition, the phenomenological observational lens will observe how the research participants describe therapist stuckness and how this description adjusts [or not] in response to the consultation model. The effectiveness of the model will be observed as directed through the reflections of the participants.
Action Stage 5: And the continuation of the reflexive/action cycle:	Task: To introduce the dialogical consultation to the next participant. The follow on participant is requested to engage. The researcher observes the participants engagement with the model. The researcher explores with the participant how they experienced the model. The activity is subsequently critiqued. The review/ feedback mechanism[71] takes place with again the cycle repeated.

[71] The review/ feedback mechanism has a number of roles, namely, it enhances participation and interest in the project, provides valuable guidance as according to Action Research guidelines, and, increases the relevance of the study [see Reason and Bradbury, 2006].

Appendix 6:

Interpretative Phenomenological Analysis lens:

Interpretative Phenomenological Analysis lens:	*Emergent themes in consultation:*	*Emergent themes in response to IPA reflexive research questions:*	*Super ordinate themes:*
<u>Pilot Study:</u> Pre Dialogical Model and pre client group meeting: What *meaning* do the participants ascribe to the projects theme i.e. therapist stuckness, in response to the opening phenomenological based question?	Dominant prejudices defines stuckness: Initially, I believed that therapist stuckness centered on a therapist not addressing all aspects of their unique internal dialogue .This belief lead me to develop a consultation model that was interested in explicating the therapists internal dialogue, identifying the components, defining the trigger, addressing and subsequently creating dialogical movement with no attention towards the social–self component or any direct interest in the client's voice and how it was internalized by myself.	Description of stuckness: initial description identifies stuckness as linear process: "a therapist not addressing all aspects of their internal dialogue" [Pilot study, 234] with no attention to towards the social–self component or any direct interest in the client's voice and how it was internalized by myself, which as the consultation proceeded became a significant component of the therapists reflexive activity.	*Theme 1*: Can stuckness be described as a dialogical phenomenon : Initial description of stuckness: Stuckness as a linear / isolated process hurdle. *Theme 1*: Position of dominant prejudices within stuck environment.
Dialogical Consultation phase: How do the participants *experience* and *engage with* the dialogical consultation?	I found the self-disclosure aspect challenging. It pushed me to use professional lexicon and systemic theories instead of reflecting on my experiences. This non-disclosure strategy blocked the development of new ideas, new reflections or new ways to proceed in the	*Theme 2: The use of Non-disclosure strategies:* The use of professional lexicon, use of systemic reflections and the re-remembering of only the positive aspects of the engagement with the client block new ideas, new reflections and the development of new ways	*Theme 6a*: Therapeutic observation of self of the therapist and subsequent therapeutic use of self blocked by the use of defense mechanisms. *Theme 2: Use of Non-disclosure strategies:* The question that arises is how do you support a therapist to

	therapeutic dialogue. At times I felt different emotions emerging, I did not directly articulate them but they did trigger an impulsive form of thinking that shifted observations and reflections back to professional parameters and systemic theories: a defense mechanism?	of proceeding. *Theme 2: Use of Non-disclosure strategies:* Emergent experiencing-self reflections trigger diversion to lexicon descriptions.	observe their experiencing – self? [See Rober, 1999, 2010].
Post Dialogical Model and post client group meeting: How do the participants *describe* their experience with the Dialogical Model? What *meaning* do the participants ascribe to the projects theme in response to their engagement with the Dialogical model?	The consultation pushes you to re-engage with the whole story of the therapeutic journey. In addition, by addressing all aspects of the engagement with the client it supports a shift from the stuck phase. The position statement and the development of a meta observational position is helpful…it allows you to sit back from the process, observe, gather your thoughts and find ways to proceed.	The Consultation can be understood as a story telling process that brings into focus all aspects of the therapeutic journey, the various characters, themes, and relationships/connections in a way that supports the develop of a meta-observation al position.	*Theme 3a*: Consultation as a dialogical story telling process. How will this process aid stuckness?
What *meaning* do the participants ascribe to the projects theme on reflection of their opening description?	Opening description: Stuckness positioned within a cognitive frame: I envisaged a structured form where it was possible to locate the *causative component.* However, my engagement with the model brought forth many questions regarding how I addressed the stuck phase. The clients voice within the therapeutic process was	The existing linear description of stuckness was challenged by my engagement with the model. Internal dialogue cannot be described in a tangible manner: dialogue more complex. To put forward a structural description is helpful in that it offers to therapist a tool for observing their thoughts and	*Theme 1: The description of stuckness* must reflect the complexity of systemic practice, the dialogical encounter and the reflexive activity of the therapist as they engage in a reciprocal/dialogic therapeutic process. *Theme 3a: Consultation as a dialogical story telling process.* Dominant themes and reflections and how they are

	highlighted therefore posed questions regarding my existing linear description. This observation also highlighted the internal dialogue. It questioned my structural description with questions centering on the dialogic or interconnected nature of reflection in response to a therapeutic encounter. Thus, the internal dialogue description cannot be described in a tangible manner. The internal dialogue is more complex and contains webs of reflections that influence and are influenced by others e.g. the moral compass voice emerged in my consultation.	experiences as they engage in therapy [see Rober, 1999, 2005a, 2005b, 2010]. However, it is a more complex composition that reflects a reciprocal reflexive dialogue that is multi layered and multi axial, a description that challenges my initial description of stuckness. Prejudices are very powerful and require time to observe comprehensibly: the question that arises is: can the model instigate a comprehensive reflexive engagement?	contained in a consultation process that embraces a dialogical storytelling format? *Theme 4: The internal dialogue as a complex web of interconnections:* *Theme 5: Can the model instigate a comprehensive reflexive engagement?*
<u>*Consultation 2 : Teresa:*</u> Pre Dialogical Model and pre client group meeting: What *meaning* do the participants ascribe to the projects theme i.e. therapist stuckness, in response to the opening phenomenological based question?	Opening description of Stuckness voiced as "a gap…a silence" [10]. This description opened out by the model questions with therapist reflecting on the difference between the family expectations and hers, what they bring to therapy, how the therapist experiences the shared family stories [emergent and historical beliefs and unspoken family rules] with a subsequent difficulty in formulating a question that will open dialogue:	Opening description: Stuckness as a technical problem opens out as consultation progresses. It moves into a reciprocal observation: Stuckness arising out of the reciprocal activity: Consultation prompts therapist to engage with all aspects of therapeutic story thus prompting an observation of stuckness as arising from the interconnections of the multiple aspects of the	*Theme 1 stuckness as a dialogical phenomenon and Task of model:* Consultation promotes a wider observation of stuckness thus prompting a dialogical framed description.

	"And for me it is how to put it into a question, that makes a therapeutic question that moves the session" [Teresa: 32-35]; and, "how do I make a question out of what I am asking myself"[51-53]. Thus from that exploration therapist viewed stuckness as a position where she was not connecting with the family: "when I put forward my observations sometimes the family don't answer" [115-117].	therapeutic encounter: E.g. Unspoken family rules: "A part of me is wondering is it that the family is using silence to stop me going down this theme?" [156-159]. "un spoken family rules may stop certain themes been discussed" [216-217]: "is it that there are just some things that you do not discuss?" [232-233]. Consultation prompting therapist to pose questions to herself regarding her as a therapist, as a unique person and how that fits with the process of systemic therapy.	*Theme 6 Therapeutic observation of self and therapeutic use of self /Task of model*: Consultation prompts therapeutic observation of self: e.g.: "Maybe it's at times I have too much pride or hold too much on that assumption or question and then when I am met with silence I see that as stuckness" [250-255]: "How do I make a question out of what I am asking myself" [51-53].
Dialogical Consultation phase: How do the participants *experience* and *engage with* the dialogical consultation?	"When I hear myself talking I am a bit surprised with myself in that I suppose it is that assumption that I have….well that they are here for Family therapy…and that they should acknowledge what I say or what questions I ask"[241-246]. "maybe it's at times I have too much pride or hold too much on that assumption or question and then when I am met with silence I see that as stuckness" [250-255]: Teresa on engaging with model is challenged with the reflection of how dominant her views can be	Therapists shifts observation from the family to herself and poses : "maybe it's at times I have too much pride or hold too much on that assumption or question and then when I am met with silence I see that as stuckness" [250-255]: This questions her assumptions. Does the consultation not allow time and pace to process emergent	*Theme 6 Consultation promotes therapist observation of self /Task of model:* Dominant assumptions, beliefs and narratives of therapist are challenged by consultation. Opens space for alternative reflections. Therapists surprised by the dominant self-narratives and challenge same. *Theme 2: use of Non-disclosure strategies:* How do therapists experience exploring their unique self in a consultation

	and that at times she overlooks the families values. This brings forth two questions: Does the consultation not allow time and pace to process emergent reflections. Moreover, what is my position in this consultation versus research activity?	reflections.	process? Non-disclosure strategies have been identified.
Post Dialogical Model and post client group meeting: How do the participants *describe* their experience with the Dialogical Model?	Teresa shared the emotions that arose in response to the family stories and the revisiting of them during the course of the consultation, she spoke of uncomfortableness, a sense of rescuing, protectiveness and [340] "maternal feelings arose" [364]. The emergence of these feelings triggered a re-surfacing of her own personal feelings, memories and values "what I value with my children" [369].Thus her experience was emotional. The emergence of these emotions prompted her to observe her values and how they connect with the families, her expectations, the family's expectations and how they connect.	Emergent therapist emotions prompted the emergence of historical experiences/beliefs and values, which in turn prompted a new or different ways of connecting with client group: 1. "Maternal feelings arose" [364]. 2. "What I value with my children" [369]. 3." As I think about the family I feel quite jarred from the family, and me and the family are different" [379-380] 4." I suppose there is a kind of clash between what I should therapeutically do and what I feel I should instinctively do…and I suppose sometimes the family don't want to go there…the instinctive path gets me to look at been a parent, what it means in a more supportive, loving way" [386-410].	*Theme 6b: Emergent emotions and their position in a consultation:* Therapists emergent emotions trigger a Trajectory of reflections that build on each other and move therapist towards a new way of observing their unique self and in response the family system and stories shared. *Theme 6a Therapeutic observation of self and therapeutic use of self:* Therefore, this would suggest the importance of articulating the emergent emotions; a process that triggers observation of self, observation of other in response to observation of self, emergent empathic responses and from that process supports new ways to proceed in a manner that connects with client group.
What *meaning* do the	"Been in tune with the	Developed description of	

participants ascribe to the projects theme on reflection of their opening description?	family" [433]. "I know that it is my own strong values on what a family is about" [465-467]. Teresa observed stuckness as a time in therapy when she was not connecting with the family stories and insights and allowing her ideas [historical and experiencing] to dominate therapeutic encounter.	stuckness in response to consultation: "Been in tune with the family" [433]: This description brings into focus the client's voice, therapist voice, the internalized other and the intersubjective space.	*Theme 1: Stuckness as a dialogical phenomenon.* Therapist shifted description from a linear, isolated description to one that fits with the dialogical frame of reflection and practice.
<u>*Consultation 3 : Michael:*</u> Pre Dialogical Model and pre client group meeting: What *meaning* do the participants ascribe to the projects theme i.e. therapist stuckness, in response to the opening phenomenological based question?	"Sometimes I panic and think what am I going to do now and there are times when I think where is this taking me"[9-16]; "is it that I am stuck, the family are stuck…or is a place where they feel uncomfortable?"[19-26]. In response to this statement I requested Michael to look at when he is stuck : " I might have let's say hypothesized about the family before they come in and thinking about a particular line of inquiry and then I meet them and something else comes up" [35-42]…. "And I am thinking how do I go from here, or, how do I respond or how do I read people" [53-57]. Michael talks about connecting with the family, similar to Teresa. Michael moves on to say	Opening description reflects an isolated phenomenon: Is it me or is it the client group? "Is it that I am stuck, the families are stuck…or is a place where they feel uncomfortable?"[19-26]. Opening description illustrates a disconnection between the therapist and client group. Therapist reflects on professional demands and remains in a theoretical systemic frame of reflection without touching on the emotional realms of therapy. This raises a question: The emotional aspect is it vital? Will it prompt a shift in therapy from *a them and us to an us activity*.	*Theme 1: Stuckness As a dialogical phenomenon:* Stuckness as a disconnection between therapist and client group. How does a therapist move from a disconnection form of reflection to a connected form of reflection? Is it necessary to draw on the experiencing-self in order to fully connect and find ways to proceed? *Theme 1: Levels of observation: Systemic versus dialogical:* Thus, a systemic approach does not necessarily mean a dialogical approach that takes into focus the internal and external dialogue of both client and therapist and how they connect: A different level of interaction, participation and connectivity?

	that stuckness is uncomfortable in that he feels pressurized to do something , that there is an expectation for something to happen: "there is an outcome or the conversation will come to a point where the people feel that something is happening" [70-80].	Professional demands pose a problem.	*Theme 7: Is it that professional parameters and expectations prompt stuckness?*
Dialogical Consultation phase: How do the participants *experience* and *engage with* the dialogical consultation?	Michael described the consultation as *an invitation* to step into the family's story and reflect on all aspects. Michael spoke of the emergence of feelings as he took part in the consultation: feelings of empathy [149], ideas of feeling trapped [151], "I want to place myself in a position where I am helpful to her" [284-287], ideas of been able to "contain this difficulty" [382-383] and shared that he felt that the emotions "invites me to be a bit more attentive to her" 169-171] e.g.: Researcher: "you mentioned about empathy where does that arise from and how does that influence therapy?" Michael: "well yes it helps me find questions or conversations that are	Michael preceded in the consultation towards a storying process that brought into focus his experiences and shared that he felt that the emotions "invites me to be a bit more attentive to her" 169-171]. Michael introduced the idea of a multiplicity of internal voices supporting his engagement with this family. This observation reflects Raggett's [2000] description with Michael supporting the idea that all internal reflections connect with and support each other: a web of positions rather than isolated voices.	*Theme 6b: Emergent emotions and their position in the consultation and therapeutic process:* Is it that therapist *emotional connectedness* enhances the therapy journey. The emotions "invites me to be a bit more attentive to her" [Michael 169-171]; and, "well yes it helps me find questions or conversations that are attending to her story of care" [Michael, 175-186]. *Theme 4: The internal dialogue: a complex web of interconnections:* "They complement each other" [364-365]. A description that reflects systemic therapy and maybe could be advanced for use in systemic training?

	attending to her story of care" [175-186]. Michael introduced the idea of a multiplicity of voices supporting his engagement with this family, moral voice, life experiencing voice, voice of respect, cultural and faith voice [356]: "They complement each other" [364-365].		
Post Dialogical Model and post client group meeting: How do the participants *describe* their experience with the Dialogical Model?	"Great sadness, and loss, loss of love" [548]. To describe his experience I quoted this line, it illustrates the sadness in the consultation, the manner in which Michael engaged in the consultation, it showed respect for the process. The consultation leads Michael through all the stories of this family, it brought forth his experiencing-self and how it supports him as a therapist. A sad story was shared, how did Michael feel post consultation? Michael spoke about the meeting with the client post consultation, he shared that he did not speak a lot, he let her do all the talking "but she told me her story and up dated it" [36-37]….and she, the client reported at the close of that meeting that she just likes to talk and have someone to listen,	"Great sadness, and loss, loss of love" [548]: quote illustrates the form of consultation; emergent self-experiences highlighting the experiences of the client group. Task of model: On a more objective account, consultation supported the development of a meta observational position that brings forth all aspects of the therapeutic trajectory and shared story. This process allowed Michael to step back and allow the client to bring the conversation to a place that was important to her.	*Theme 6a Therapeutic observation and use of self:* Consultation as a self-reflexive activity that brings forth self-experiencing emotions and how they support a therapist. *Theme 3b: A broadened description of the meta observational position*: a dialogical description: Consultation supported the development of a *meta-observational position* that brings forth all aspects of the therapeutic trajectory and shared story. Supports the therapist and removes the sense of professional responsibility to find the answers. *Theme 7: Professional expectations and responsibility can overshadow the client's* story.

	"and that you do not criticize me [47]". This response from the client helped Michael in that some of the weight was removed from his shoulders some of the responsibility to save this woman. He also thought of the parallel stories in his own head, the client's stories and his own stories of his own family and how they connect with each other, and supports each other. Michael "and those things about been stuck and I found it …well I wouldn't use the word liberating but something like that" [108-110]….or me trying to direct the conversation with an expectation to get a certain answer [210-212]: "I need to listen to this woman" [214]. Michael described a process of stepping back and allowing the client to bring the conversation to a place that was important to her. Objective account: "found talking to someone else about a particular case that was really helpful" [630-633]. "Helping me to understand my own thinking and views in relation to a piece of work" [634-638].	<u>Task of model</u>: A dialogical observation of therapeutic activity. <u>Task of model</u>: Objective account: "found talking to someone else about a particular case that was really helpful" [630-633]. <u>Task of model:</u> development of meta-observational position Theme 3a: Consultation as a story telling process?	*Theme 3a: Consultation as a dialogical storytelling process that draws on dialogue and Gadamerian hermeneutics.*

	This is a retrospective reflection: I have just completed all consultation and with interest was drawn towards following how Michael told the story of his encounter with the client group. He moved through a number of themes, weaving together a story, a story of sadness, and loss; and, as the story moved towards the closing reflection, hope entered the narrative. Therefore, is this form of consultation a story telling process?		
What *meaning* do the participants ascribe to the projects theme on reflection of their opening description?	Michael's description of stuckness altered. He reflected on his position in therapy with an initial position of entering therapy with a hypothesis to "A not knowing position" [384]: "In my own head I am already thinking ahead and had worked something out" [Michael: 313]; to: "I am listening differently, I am listening more attentive" [398-400]. He observes that he *"Stepped deeper into her story"* [485-486].Therefore, Michael's description of stuckness reflects Teresa's: connectedness and attentiveness to where the family is at and where they see their horizons, how that	Description of stuckness moves towards a dialogical description that brings into play the internalized other, the client's story, how it is heard by the therapist and the third space. Reflects consultation 2: connectivity and attentively. <u>Task of model</u>: "Stepped deeper into her story" [485-486]. <u>Task of model:</u> is it that the consultation process as directed through a dialogical frame brings forth the richness of systemic therapy <u>Task of model</u>: Did the model instigate this rich	*Theme 1: Stuckness as dialogic phenomena:* Connectivity and attentiveness: "I am listening differently, I am listening more attentive" [Michael: 398-400]. <u>Task of model:</u> The development of a thicker description that emerges from the client's voice, the internalized other, the dialogic interplay, the empathic responses and ideas of how to proceed: "Stepped deeper into her story" [485-486]. "I am listening differently, I am listening more attentive" [398-400]. *Theme 3a: Consultation as a*

	connects with their ideas both historical and here and now, and how they can advance in a way that moves at the families pace. After re-reading Michaels consultation, it came to light that it presents as an ebb and flow of reflections that fit together to create a master story. Michael presented to us a cast of characters, a variety of themes, and a complex narrative that moves towards a master story that incorporates all. Does it reduce the richness of real life? The emotions are expressed. The characters are given identities that illustrate their frailties and contradictions. Moreover, by doing so we see the richness of systemic therapy.	story or bring to fore the real texture of therapy? How do we now read this current form of consultation: As an intimate portrait of the client group and how they are observed by the therapist? Alternatively, as a story of the client group/therapist encounter, a dialogic storytelling process that moves between real time, historical time, and all the different characters in a way that allows all to be heard? With the second option, it would have roots in narrative, dialogue and relational hermeneutics. Storytelling through a dialogic lens brings forward a different form of narrative, a dialogic narrative. I will revisit the final draft [post consultation 6] and re-read with the idea of storytelling leading the reading. [see discussion chapter]	*dialogical story telling process* that brings together a synergy of ideas from narrative, dialogue and hermeneutics, a different from of storytelling. Task of model: is it that Storytelling through a dialogic lens brings forward a different form of narrative, a dialogic narrative.
Consultation 4 : Kathleen: Pre Dialogical Model and pre client group meeting: What *meaning* do the participants ascribe to the projects theme i.e. therapist	Powerful self-experiencing reflections leading the consultations: It brought forward strong self-experiencing emotions with a central image of motherhood and nurturing	Central image of motherhood and nurturing leading the reflections and the consultation. Description of stuckness	The emotional aspect of therapy, with, the emotional aspect of consultation: how to balance and contain in a consultation process. Task of model: A dialogic

stuckness, in response to the opening phenomenological based question?	leading the reflections and the consultation. The initial description was linear and reflected stuckness as a technical problem: "…to join with them and hear their stories and …just not knowing where to go with it… [11-13]. Again, as the consultation progressed the description moved towards a dialogic observation that brought into focus how she connects with the client group , with reference towards how they observe their family story and what their expectations are at that moment in time, and, how she observes their story with historical beliefs and values leading this reflection. Again, this consultation reflects a story telling activity, Kathleen moved through the various perspectives and actors in a way that supported the development of a coherent story that contained characters, story lines, themes, emotions and forward horizons.	started with a technical description :Stuckness as a hesitation in response [technical setback] Description moved from observing stuckness as a disconnection between therapist and client group to a description that calls to attention the multiple domains of perspectives, the clients groups perspective ["and the idea of systemic can be very challenging for some people"][53-54], how they see their position, the stories they share and don't share, how the therapist observes the clients group story, how the story connects with her historical and here-and-now self and how they can find ways to proceed: a description that fits with the dialogical perspective: "sometimes the conversation in my head is totally different form the one that I am happening with me and the family and then I feel myself getting stuck" [30-35]. " a difference for me is when I name it…I suppose I really have to listen rather than just hearing my inner voice telling me…what are my expectations possibly internally and do they fit or are they realistic with the	observation: triggers therapist to observe stuckness through a dialogical lens thereby offering new ways to proceed. It opens out the storytelling process to include both the internal and external stories of both therapist and client. *Theme 3a: Consultation as a dialogic story telling process*.

		families ideas" [31-37].	
Dialogical Consultation phase: How do the participants *experience* and *engage with* the dialogical consultation?	The engagement with this model brought forth many emotions for the therapist, it prompted a self-observation of her unique self and how she observes herself outside of therapy and in therapy. Her reflexive process moved through the four levels of reflection as developed through observing the consultation to this point: <u>Reflection level 1: self-reflection</u>:" well yes I'm thinking about my hypothesis and I'm thinking that I have formulations I suppose I tend to think in a very logical way but with this family I sense an inner sense there is a lot of worries"[123-128]. <u>Reflection level 2: A move towards internalized client group voice</u>: "well lots of worries of the family and a lot of safety and not a lot of understanding about what relationships are safe or not safe …well I suppose it is a worry about a real strong worry about parenting"[130-139]. <u>Reflection level 3 [empathic reflections]:</u> "well I suppose what I am thinking about is my experiences of been	Consultation prompts a self-observation, therapeutic use of self process: Four levels of reflection: 1. Self as a therapist, self as a unique person and the connection. 2. Observation of the internalized other. 3. Empathic reflections in response to reflection of self and of other. 4. Response building reflections with a move towards a mutual intersubjective space e.g. : "I think I might ask them about their current experience and where I fit with it because there are a lot of people in their lives and how does that make them feel and what is it like to have conversations with so many people" [221-228] .	*Theme 6a: Therapeutic observation of self and therapeutic use of self* supports empathic reflections and thus promotes connectivity and attentiveness to client group.

	parented and I look at this family and wonder did they experience or what experiences did they have and how does that come out in their day to day life"[144-150]. Reflection level 3 [empathic reflection]: "I suppose when I listen to the family and hear the stories of how they care and look after each other and I think of my experiences...I wonder how I understand that or what that meant and how does it reflect with what I hear from this family"[191-197]. Reflection level 4 [response building phase]: "I suppose it is about getting emotional connected with the family" [309-310]; and , " and that's when I started thinking about my own experiences of myself and I consciously reflect back to my experiences and their experiences and my expectations of them …although it does not appear to fit with their experiences…and I suppose I see a shift in me…maybe influencing how I see this family…that is been a parent brings a another new idea of maybe how I can connect with them" [239-255].	Or therapeutic use of self: self-reflection, a move towards internalized client group voice, empathic reflections, and response Emotions prompt new ways of reflecting on self, on other, and on how to move forward in therapy. Emotions prompts, strengthens and connects with other: *A human activity.*	*Theme 3a: Consultation as a story construction process that is guided by the four levels of therapeutic use of self-reflections.* *Theme 8: A human activity*: Emotions prompt new ways of reflecting on self, on other, and on how to move forward in therapy. Emotions prompts, strengthens and connects with other.

	This evolving self-reflexive activity brought forth emotions of empathy, care and shifts engagement towards a mutual intersubjective space: "but now I feel they want the best for their children but they are unsure of how to go about it" [260-263]. This reflection prompts new ways of going forward with client group.		
Post Dialogical Model and post client group meeting: How do the participants *describe* their experience with the Dialogical Model?	The experiencing-self was central to this consultation: "I feel quite protective …I kind of feel for the children" [258-259]... Again, it told a story, but the story was weaved together by the experiences of the therapist. *The experiencing self became the silent central.* The story development shifted the therapist to a meta- observational position that not only addressed where the therapeutic trajectory was at but also where she was as a therapist and a unique person: "I think that maybe I need to take a deep breath and maybe link in with myself and where I am at" [283-285]. The meta observational position from this	Again, it told a story, but the story was weaved together by the experiences of the therapist. The experiencing self became the silent central. Meta-observational position two tasks: focuses the therapists to observe where the therapeutic trajectory is at and where she as a therapist and as a unique person is at. Storying process supports meta observational position Close connection between the person of the therapist and the person as a unique individual.	*Theme 8*: *The human aspect of therapy:* the experiencing Self-: A silent central. *Theme 6a: Therapeutic observation and use of self: PS= observational position*=directs attention to where the therapeutic trajectory is at and where the participant as a therapist is at, and where they are as a unique person: "I think that maybe I need to take a deep breath and maybe link in with myself and where I am at" [Kathleen: 283-285]. *Theme 6a Therapeutic observation and use of self*: consultation directs attention to the therapist as a clinician, as a unique person and the interconnections.

	consultation arises as a more complex position. The post consultation review put forward a number of reflections: "Such reflections allowed me to consider my own beliefs, values and expectations of therapeutic change" [8-9]. "And reflect on the client's groups voice in terms of value placed on support rather than change"[11-12]: beliefs were identified as triggers to stuckness with an opening out observation of all perspectives, to be seen as a move from stuckness. The therapeutic process shifted post consultation to connecting with the family and allowing more space to what they consider to be of value for their family*: "real in listening" [post* consultation : 23]. The idea of fixing the family shifted reflects Michael's ideas. "I realized that I was working hard to convince a family that I have the answer…and I have lost sight of the value I place on the relational piece of joining with the family"[post consultation: 30-33]. "I believe in the future it	<u>Professional expectations:</u> "I realized that I was working hard to convince a family that I have the answer" [30=31] Therapy as a dialogical encounter: " it allowed me to see them as parents who want the best for their children…It allowed me to provide space for the family voice…to consider hearing their stories differently"[168-170]. "Real listening" [Kathleen: post, 23] reflects Michaels idea of model.	*Theme 7: Professional expectations and parameters*. *Theme 8: The human aspect of therapy*: real listening, listening to her story, and the emergent emotions that trigger empathic reflection and response.

	will alter the style of dialogue I have with families ...I will try to be more actively recognize my positions and emotions, bring that into the room but also engage in a more curious stance with families meanings and emotionality in conversations" [43-46]…allowed therapist to be more flexible and reach out from a more curious position.		
What *meaning* do the participants ascribe to the projects theme on reflection of their opening description? Position statements: 1. Family vulnerability, difficulty/confusion. In engaging in a systemic conversation. 2. Emotional connections.	Description of stuckness moved towards a dialogic description: "And maybe another question that I may have is to ask them about their family of origin because I have tried to get them to talk about it...but we never got there…and that's when I start thinking of my own experiences and my expectations of them…although it might not fit with their experiences…and I suppose I see a shift in me…with my own parenting and how I see them through my own experiences of been parented and now I am a parent" [233-250]: And, post consultation review: "I now view the stuck phase as not about a difference in	Dialogical description of stuckness as triggered by model through the process of storytelling and reflexive platforms: "Emotional connections" P.S.2. Self-reflections strengthen empathic reflections and thus connection with client group.	*Theme 1: Stuckness as observed through a dialogical lens.*

	opinion or the families resistance to change , but more as a stuckness in my internal positions in terms of being married to my assumptions and not connecting with the unknown stories of families [post consultation review: 15-17].		
<u>*Consultation 5 : Elizabeth:*</u> Pre Dialogical Model and pre client group meeting: What *meaning* do the participants ascribe to the projects theme i.e. therapist stuckness, in response to the opening phenomenological based question?	Elizabeth at the opening of the consultation described her experience of stuckness as arising from individual members of the family having difficulties in achieving the assigned professional task with her as a therapist feeling a sense of hopelessness [post consultation: 20-23]. The consultation in action began with Elizabeth sharing that the key concern centered on the young girls difficulty to attend school. This theme dominated her work with the family. This professional theme overshadowed all other family narratives: "the girl had latched onto not going to school…and the mother held onto that in the sessions…and the more you go on [with not attending school] it becomes less straight forward" [37-43].	Opening description of stuckness: Professional parameter stuckness, a linear isolated description. Dominant professional theme lead therapeutic trajectory thus overshadowing all other stories. Thus, stuckness reflected one aspect of family story.	*Theme 7: Professional expectations and parameters* can dictate therapeutic trajectory. Can dictate unachievable goals that overshadow other aspects of family.

Dialogical Consultation phase: How do the participants *experience* and *engage with* the dialogical consultation?	The consultation commenced with the dominant story of non-school attendance. From the therapist description, it was shielding all other stories, as it was a difficult theme to ignore in the professional world of adolescent mental health care. *It obscured all other narratives.* To move the consultation narrative I posed "are there any other systemic ideas emerging?" The therapist in response brought forward a number of themes: school refusal prompted the idea of attachment, nurturing and the need to be near her mother: "It seems the key feature in that she needs to be near home and maybe cared for? *Nurtured?*" [47-49]. Therapist shifted her observational lens by exploring non-school attendance through different lenses: caring lens, attachment lens, supportive lens [i.e. how can other members of the family support young person: "dad needs to be involved more" 64-66]. This opening out	Consultation opened out family story and introduced other aspects of story, family and therapists engagement with process. "Are there any other systemic ideas emerging? "With experiencing reflections emerging. There was again hesitancy in responding to the experiencing questions. The experiencing self can become subsumed: Therapist went on to share that the professional lens obscured all other stories and all feelings of connectedness. *Stalemate: how to stay connected.* Is a consultation at the start of the therapeutic process more advantageous than at the latter stage? Emotions and the experiencing self become silenced? Therapist as a unique person heightened in response to experiencing questions: "I think I need to touch base with myself…but I like the whole idea of looking to yourself and what it is because…" [151-154].	<u>Task of model</u>: Consultation as a process that creates a thicker description of client group. *Theme 7: Professional expectations and parameters: It obscured all other narratives* *Theme 6a and 6b: Experiencing self of therapist subsumed by other voices and by the use of defense strategies.* *Theme 6a and 6b: The 4 Reflexive phases: Are they natural to systemic practice*?

	dialogue created new lines of inquiry. Therapist's response to the experiencing line of inquiry was hesitant. I feel the questions were to abstract. Therapist's response to experiencing questions reflected systemic ideas. Therapist went on to share that the professional lens obscured all other stories and all feelings of connectedness. "But then I got all caught up in the whole thing about school and got held in that theme" [82-84]. The therapist followed this with a further systemic observation: "like there is a hunch in that sometimes I think she does have a real power in the family" [88-90]. The experiencing domain of reflection did not necessarily emerge. The final question: what questions have you not asked so far? Prompted the therapist to view all emergent ideas and reflect on ways to go forward. "Absolutely I will revisit the whole family and get to know the whole family…and I think that it is worth doing" 122-124]. The dominant theme had lost its grip with the therapist	. This is interesting in that from this consultation, when a therapist first meets with a family, they can sense the emergent emotions as the trajectory progresses and if a stalemate arises, the emotions flatten? The question is how do you stay connected? Model prompts meta observational position and brings therapist to a position *that views all stories as worthy:* "Absolutely I will revisit the whole family and get to know the whole family…and I think that it is worth doing" 122-124].	*Theme: 2 Use of non-disclosure strategies. Broad systemic ideas.* *Theme 7: professional expectations and parameters*. *Theme 3b: A broadened description of the meta observational position.*

	reflecting on stepping back into meeting with this family in a more open curious mode of observation and participation: "I feel more energized" [140].		
Post Dialogical Model and post client group meeting: How do the participants *describe* their experience with the Dialogical Model? What *meaning* do the participants ascribe to the projects theme in response to their engagement with the Dialogical model?	Therapist shared that she found engaging with the model useful in that it supported a broadening out of the story [post consultation: 1-2]. She shared that she moved from the dominant story to observing the relationships and interactions of the family [4-5]. This change prompted new lines of inquiry: "I am going to invite the couple to a session alone, which is something that I had happened in the past on one occasion and when I reflected on that session had remembered it has been very interesting and bringing up loads of avenues for discussion and consideration between the parents about their lives together when younger and how things have evolved" [post consultation: 10-14]. "The negative cycle that we had drifted into shifted and the feelings of hopelessness also shifted both for me and also for the family" [post	Task of model: As model progressed: 1. dominant theme lost its grip. 2. Model prompts broadening out of story. 3. Moved from observing family story to observing relational aspects of family and self of therapist in the context of the systemic encounter. Energized, new ways of engaging with family, curious… *Theme 6a and 6b: Therapeutic use of self seen as a useful tool…"*It is good [vital] to take the time to reflect on and return to the human side of ourselves and our own life experiences. Through therapeutic use of self, therapist is invited to revisit completely family story in a dialogical manner that brings into focus experiencing self.	*Theme 3b a broadened description of the meta observational position:* Model: shifts the observational lens: views all perspectives, both self-experiencing of therapist and family, stories and themes in a manner that balances. *Theme 3a: dialogical storytelling and consultation: A shift in depth?* *Theme 6a and 6b: Therapeutic observation of self/therapeutic use of self* equates with a more

	consultation: 15-17]. "Broadened out the dialogue" [post consultation: 26]. "Regained my curiosity" [post consultation: 28]. Post consultation dialogue: Therapist was prompted to touch on her experiencing self. She talked about her experience of been a mother, a wife and a female and that these reflections prompted new ways of engaging with family: "my thoughts were re-energized which had an impact on the dialogue through my questions considering the mothers role as a mother and her thoughts that she had failed her children and her husband in their early life" [post consultation: 86-88]. "the use and reflection of the self of the therapist is key in this and can be helpful in promoting a change in questions focus …a sharing of experience" 106-107]…"It is good [vital] to take the time to reflect on and return to the human side of ourselves and our own life experiences, which influences our actions and reactions in our shared communications a therapists with our clients and not to get caught up in	Task of model: Definition of model provided by therapist: "The dialogical model is a model that is helpful in offering a guide to considering our interactions and conversations with our clients in that it encourages focus on what is emerging in the dialogue between you and the client and how our questions are formed by this flow which can promote new ways of thinking and talking about aspects of our lives which we consider to be problematic, or limiting and negative [post consultation: 108-112].	attentive and connected approach to therapy. Is this a dialogical approach?

	theories and take on others subjective views [team/society] without consideration of where these have come from and how they influence our interactions [post consultations: 113-116].		
What *meaning* do the participants ascribe to the projects theme on reflection of their opening description?	Dialogical description emerged: " I realize that with reflection I was inadvertently being a vessel for encouraging this [dominant theme] and was holding these thoughts and ideas in a session, which the family were also holding and seeking to achieve, without allowing the space for a different way of moving forward" [post consultation: 54-57].	Stuckness as triggered by a dominant theme [54]: "been a vessel".	Theme 1: Stuckness observed through a dialogical lens brings forth new ways of going forward.
<u>*Consultation 6 : Johanna:*</u> Pre Dialogical Model and pre client group meeting: What *meaning* do the participants ascribe to the projects theme i.e. therapist stuckness, in response to the opening phenomenological based question?	Task to observe consultation in light of emergent themes in earlier consultations: Therapists introduced the idea of professional/systemic stuckness: "when a parent pays for the appointment, I become stuck with the session as I am going with their expectations" [Johanna: 5-9]. "Like the contract at the start is with the client, the young person, and they like to come on their own, and we will build in some meetings with the	Initial description of stuckness reflected a professional lens with boundaries a key factor. As discussion progressed, the lens broadened to include systemic ideas and practices that could prompt stuckness. This discussion raises ethical and moral reflections for therapist. Again illustrating the more complex picture of stuckness. Professional expectations	*Theme 1: stuckness description shifts from linear/isolated description to a dialogical description:* isolated factor to a constellation of factors: The initial description of stuckness as described by all participants defined by an isolated factor. As discussion progresses each therapist broadened his or her description. Stuckness as a phase where a number of factors meet and trigger a stuck phase: moral, ethical, historical, here and now experiencing, expectations of family and therapist. Reflects ideas of N.

	parents…and the question is who is my client" [Johanna:]. "like they see their child attending therapy and feel they should be part of it, and so I think of space, or think about therapeutic thrust and wonder how I fit in, so it's like the parents request feedback…and the question is who is my client" [J: 11-18]	and parameters delineate therapy.	Byrne [fifth province] and C. Flaskas, the constellation ideas.
Dialogical Consultation phase: How do the participants *experience* and *engage with* the dialogical consultation?	Therapist shared systemic ideas : insecure boundaries : " I get drawn into conversations with the parents "[24-25], professional ideas, "It's like I have no options or no way to go on"[32-32], "it's like I'm trying to work and at the same time balance confidentiality…like they have a right to feedback" [54-58] and experiencing reflections, "well yes one thing that has come up …is that I wonder does she really want to get better" [163-165] ; systemic lens with a subliminal ethical/morel lens: "I think it was when I got distracted from listening…missing what was been said and …like thinking what would that be like for the parents to hear" [77-80].	*Theme 4: The internal dialogue: a complex web:* Complex environment of systemic practice mirrors complex internal dialogue of therapist. *Theme 2 Non-disclosure mechanism*: therapist shifts into externalizing themselves from the family system and therapeutic activity: "well I do think of the parents and all the work they do and I do like to be helpful" [135-137]. In addition, therapist brings into discussion systemic ideas in an attempt to distance from experiencing reflections. Systemic ideas are neutral: "and when I see this family and all the dynamics it is interesting" [140-141].	<u>Task of model</u>: The position of the researcher and of a consultant*:* Collaborative interplay to be built into consultation process promotes deeper reflexive activity. <u>Task of model</u>: The model aims to broaden each reflexive step, prompt the therapist to connect more closely with each step and from that process develop their observation of their self, their position in the therapeutic interplay, and the client's group's position, with the development of a more inclusive meta position. *Theme 2: Non-disclosure strategies: Levels of defensiveness to collaborative interplay.* Collaborative interplay style of consultation promotes a more open, reflexive meeting. By been aware of non-disclosure

			strategies or mechanisms supports a more reflexive consultation activity.
Post Dialogical Model and post client group meeting: How do the participants *describe* their experience with the Dialogical Model?	Therapist employed a number of non-disclosure mechanisms in order not to reflect on the experiencing aspect of therapy. That is by the use of broad themes, systemic themes, and externalizing from activity: Broad systemic lens that externalizes her from the activity: "well I suppose I haven't looked at the young person as a part of the system "[235-236]. And distancing from experiencing reflections: "as we have gone through it and I suppose I never looked at what was going on in my gut and that maybe I had a bias that I wasn't aware of and now that I have verbalized it I think that it could be useful" [250-255]. Therapist did at close of session touch on "hunches" and employed them in a manner that was positive [positive reframing]: "well I suppose one thing that has come up is that I wonder does she want to get better in that she has invested in this role " [167-168], therapist reflects on this in a positive manner and	Positive reframing of hunches Hunches as silent central and enabling factor. *Theme 2: Use of non-disclosure mechanisms:* broad themes, systemic themes, and externalizing from activity and from self-experiencing reflections.	*Theme 2: Non-disclosure strategies in systemic practice isolate the experiencing domain of reflection.* Use of hunches as an enabling factor in therapeutic process: this participant illustrated how hunches can be utilized in a constructive way.

	attempts to find ways to introduce it into the therapy in a constructive way: " and I wonder what would it be like if she was really motivated?" [184-187].		
What *meaning* do the participants ascribe to the projects theme on reflection of their opening description? PS 1: "What is my role?"[J: 89]: initial interpretation of stuckness PS 2: freedom and multiple ideas.	Therapists spoke of feeling a sense of *freedom* post consultation [1-3], therefore from that description I take that stuckness refers to been locked into a position where there is no choices? Therapists refer to freedom as having a multiple of ideas [5]. Therapist spoke of the initial understanding and sense of responsibility towards the parents i.e. professional stuckness "with a shift of focus to "the words that were been spoken by the young person" [11-12]. "It did help greatly as I felt freer once I engaged with what was going on in my gut. By addressing this and focusing on it, it freed me up" [15-16].	Shift from professional parameter to broader description of stuckness that brought into play the systemic ideas, all perspectives and expectations, with a silent central, the "gut" reflections. Therapist moved to a position where she observes the tension between the professional, systemic and experiencing positions with a look at how to move forward. *Theme 2: defense strategies: Shift from externalizing from encounter to addressing all ideas*. Maybe introduce this question: "Are there times in therapy that you draw on your experiencing-self or hunches?	*Theme 7: The professional expectations and parameters.* *Theme 8 The human activity:* Consultation as a journey that reflects the therapists positioning and readiness to engage and reflect: Reference to explicating gut position: brings to the fore the essential nature of reflecting and the need to go at the therapists pace. The model cannot rush reflections; the therapist will observe ideas at their own pace, absorb ideas at their own pace and translate at their own pace. Thus, the model raises ideas and platforms of reflections rather than instigate change?

Appendix 7:

Examples of transcribed and coded interviews:

Example 1: Michael's consultation:

R: Researcher. P: Participant.

Transcript:	*Emergent themes:*	*The super ordinate themes that the emergent themes support:*
R: We will be talking about a stuck phase in therapy that you are experiencing ….so I suppose the first question is how do you experience a stuck phase? P: Really interesting question... sometimes I panic and I think oh my god what am I going to do now and there are times when I think emmhh.... where is this taking me and I am always interested in where is that idea or feeling comes from about been stuck, is it that I am stuck or that the conversation is stuck, the family of the group are stuck or one member of the family is stuck or is in a place where they feel uncomfortable or to get involved in therapy.. R: let's go back to where you were mentioning that at times you could feel yourself getting stuck... P: Yes there are times when I would be prepared to see, I work a lot with	Michaels opening description appears to describe stuckness as a conversational roadblock, a description that lends itself to a structured therapeutic process that has a pre-planned outcome. However at the same time Michael leans towards the idea that the therapeutic conversation can follow its own path, be creative and spontaneous "where is this taking me?", a description that fits more comfortably with the dialogical approach.	Stuckness as a process step in a therapeutic trajectory, a step that can be a catalyst to creative reflection?

individuals, and I might have let's say hypothesized about the family before they come in and thinking about a particular line of inquiry and then I meet them and something else comes up or the way that I thought the conversation would go doesn't go that way and that sometimes can create a stuckness for me it doesn't last very long but it creates a place for me where I am thinking where do I go from here or how do I respond or how do I read people with what is going on, or how do I listen so that I am in a dialogical conversational place with them and there are times to acknowledge that either the content of the conversation or the emotional physical response of myself is saying to me that this isn't working or how do I respond , sometimes it can be an uncomfortable place because I'm thinking about that I have a time here that I need to do something or that I am under pressure to do something , in that I have an expectation that I want to get to a place where there is an outcome or the conversation will come to a point that where the people feel that something is happening here ….	Michael moves again over towards describing the therapeutic encounter in a structural pre planned way: "and I might have let's say hypothesized about the family before they come in and thinking about a particular line of inquiry", this description shifts to a more dialogical approach. Interesting shifts. Structure appears to provide reassurance, yet when Michael enters the therapeutic process a more creative, in the moment process appears to emerge: "But it creates a place for me where I am thinking where do I go from here or how do I respond". The ideas of Carmel Flaskas emerges in Michaels reflections i.e. Stuckness as a constellation of triggers: therapist stuckness as a conversational roadblock or as a professional roadblock or as a therapist roadblock...is it possible to separate the triggers out or are they all interconnected and fit on a continuum ? An interesting shift back to the professional aspect of therapy: "because I'm thinking about that I have a time here	Stuckness as an opportunity for newness. Stuckness as a dynamic evolving component of the therapeutic encounter. The professional voice and how it influences and fits into the

	that I need to do something".	therapeutic trajectory.

Example 2: Kathleen's consultation:

Transcript:	*Emergent themes:*	*The super ordinate themes that the emergent themes support:*
P: "Well my sense is that the conversation that I have with them tend to focus on the same issues and when you try to introduce something new or different there is rigidity and I have come to the point where I think maybe I should try this and then I just feel what would be the use and … R: I see... I've been there... P: Which is what I don't like feeling , and sometimes the conversation that I have in my head is totally different from the conversation that is happening with me and family and then I feel myself getting stuck…I feel they won't try and I feel an opposition to any new ideas or ..And they become more set in their ways.... R: do you feel that the family become stuck … P: Well, a difference for me is when I name it...I suppose I really have to listen rather than just hearing my inner voice telling me…what are my expectations possibly internally and do they fit or are they realistic with the	Stuckness as triggered by dominant themes as influenced by the clinical picture. Therapist reflexive processes isolated from therapeutic encounter: How do you support a therapist to self reflect and from that position translate the emergent ideas, reflections and observations into the therapeutic encounter? : "and sometimes the conversation that I have in my head is totally different from the conversation that is happening with me and family and then I feel myself getting".	Professional parameters influence the therapeutic process. Therapist internal dialogue: a complex activity that can remain separate from the therapeutic dialogue.

families ideas or expectations R: Just a little bit more on that and I am thinking about you as the therapist…what is it like to sit and hear this families stories... P: When I sit with them and hear their stories I …I hear very much talking in traditions and their voice but not hearing the other people or not linking with the others present [present]… R: what is that like P: well I suppose I want to hear every one and I try to draw them into my voice is important… I do find that very challenging in that I try to draw them out and try to bring in the other voices…and the idea of systemic can be very challenging to some people …the idea let's say like I wonder what he is thinking?	Interestingly, the therapist shifts to the family lens, shifts to their voice, a natural shift in systemic thinking... I am just wondering where is the therapist experiencing-self. Again my bias to explicate the experiencing-voice of the therapist, I observe at this stage of the research that it is not something that comes naturally to systemic therapists? "what is that like": I posed this question with the aim to prompt the therapist to look at their own experiencing and with interest the therapist brings together her own experiencing with that of the client group: therapist finds it challenging and wonders how some clients find it difficult to view their story from a systemic lens: is it not possible to isolate the experiencing self of the therapist? *[Position statement: Family vulnerability, difficulty, confusion, in engaging in systemic conversation]*.Interview has shifted from observing the experiencing – self of the therapist to observing the systemic ideas, not too sure if this is a good way to encourage reflection? Moving back and forth between systemic and experiencing? The aim is to generate an observational	The family voice: central anchor or lens in systemic reflection. The therapist experiencing-self observational process is not an isolated activity but a process step in a complex dynamic trajectory. Not possible to separate the therapist's reflections from the family system: a conjoined reflexive activity. To observe the family system, the therapeutic trajectory promotes the therapists to self observe.

	position...	

Appendix 8:

Evolving format of interview and Dialogical Consultation Model:

Draft One: Pilot Dialogical Consultation Format:

Phase One of Interview: Pre: Client Group Meeting:

Aim:

I. To stimulate reflexive thought about a stuck phase with research participants. The reflexive questions will be guided by the dialogical mode of inquiry.
II. To externalise the internal dialogical activity of the therapist with the aim to trace the internal positions, the emerging positions, the presence of flexibility, inflexibility, and position dominance and weakness in response to a stuck phase:

Pre interview exploratory dialogue:

Explore with participant how they would generally approach a stuck episode.

Researcher to introduce the dialogical approach to a stuck episode and request participant to partake in consultation influenced by dialogical theories.

Questions:

1st phase: Aim: To commence understanding the semiotic movement towards the stuck phase: Opening Dialogue: Researcher requests participant to describe the stuck phase that they are encountering:

Therapist lens:

1. "I would like you to describe the stuck encounter that you have are experiencing". Progress dialogue into understanding the semiotic movement towards the stuck phase.
2. "When did you notice stuckness?"
3. "How did you notice that you were moving into a stuck situation?"
4. "How was this experience different from a period in therapy that you felt there was movement?"

Family Lens: with the aim to elicit the potential for the influence of particular family stories, presentations, idiosyncratic positions or voices as manifested by the family that may evoke therapist prejudices etc.

1. “Did you observe a change in the family in their response to you or the therapeutic encounter?”
2. “What stories were they sharing?”
3. “What voices or positions was each member of the family using?”

2nd Phase:

Aim: To begin externalising the internal semiotic process of the therapist as they are experiencing the stuck phase and to establish an *initial position* towards the stuck phase: Opening dialogue. Researcher requests participant to identify the positions or voices from which they frame the stuck experience e.g. theoretical or experiencing frame:

Questions that assist in eliciting internal dialogue:

1. “What dominant ideas did you have?”[Potential to elicit dominant theoretical positions]
2. “What secondary ideas did you have?”[Potential to elicit further theoretical positions, with the aim to enrich dialogue or highlight adherence to theoretical position]
3. “What questions did you pose to yourself?”[Potential to elicit self-experiencing, hunches]
4. “What theoretical questions arose?”
5. “What hunches did you experience?” [Potential to elicit tension between theoretical and the experiencing positions]

2nd Phase:

Aim: The Initial Evaluation i.e. to establish an *initial position* towards the stuck phase: The participant is requested to formulate a specific personal sentence that will refer to their *initial position*: [This statement equates with the therapists meta-position or executive position as described by Stiles [1999], Rober [2008a]:

P.S. 1: “How can you now describe the stuck phase?”

3rd Phase:

Aim: Enactment of internal dialogues as drawn from the ideas of the dialogical–self theories and the ideas of Rober [1999; 2008a; 2008b]: Participant requested to further explicate the semiotic process and to explicate the relationship/tension between positions as evoked by therapeutic encounter i.e. to look a stuck phase through alternative frames or alternative

internal positions and compare; and, subsequently to expand on the initial internal position e.g. questions:

1. "What questions do you think you could ask?"
2. "What questions have you not asked so far?"
3. "Did any of your ideas or hunches surprise you?"
4. "Did any of your ideas or hunches perturb you?"
5. "What would your instinctual self or self-experiencing self say to you about the problem?"
6. "What is your instinctual self telling you to look at?"
7. "What would your professional or theoretical self say about the problem?"
8. "What is your theoretical self telling you about your experiences?"
9. "What are your experiences telling you to do?"
10. "Are these feelings, hunches and ideas familiar?"
11. "Are any of the ideas, feelings or hunches unfamiliar?"
12. "Is this client group inviting a change in your approach or your way of understanding?"
13. "Is this client group evoking positions that you do not normally utilise?"
14. "If so, is this process uncomfortable, or is it comfortable?"

4th Phase:

Aim: Second evaluation: Participant requested to refer to *initial internal position* and explore position; to reflect on developed expanded and alternative positions, and to explore if these positions would alter the *initial internal position.*

5th Phase:

Aim: To further explicate the emergent internal positions, the symbiotic relationship between internal positions, to explicate the semiotic process and establish if there is a fragmented development i.e. meaning bridges between positions are not evolving or evolved [see Stiles, 1999]; the influence of repetitiveness, innovation and the potential introduction of movement: The researcher will present the following questions: When we explore the stuck experience:

1. "What voice is the strongest?"
2. "What voice is in the background?"

3. "Where do these voices come from? [E.g. Historical, theoretical, social and experiencing; here-and-now voice; inchoate voice, critical case and heuristic processing voice; unknown?];
4. "Tell me more about the voices, where do they come from and why now?"
5. "What are these voices telling you to do?"
6. "Do the voices like each other?"
7. "Do the voices dislike each other?"
8. "Do the dominant and minor voices tell you to ignore other voices?"
9. "Do the dominant or minor voices tell you to listen to other voices?"
10. "Do any voices surprise you?"
11. "Do any of the stories of the voices surprise you?
12. "Do any of these stories prompt or evoke other voices that you had forgotten about" or "Do these stories prompt new voices or prompt new-self experiencing stories?" [*Aim: to trace semiotic development or movement]*

<u>6th Phase: Evaluation phase:</u>

1. "Tell me about how we can move forward?"
2. "Tell me how can we remain stuck?"
3. "When you move through the internal dialogue are there any surprises?"
4. "How do you think you will introduce your ideas into the therapeutic process?"

Request participant to look at *initial position* and consider would they revise their position.

Draft 2: Dialogical Consultation 1 Format:

<u>Opening task</u>: Introduction to Dialogical lens and Consultation Model:

Aim of Consultation:

To stimulate reflexive thought about a stuck phase with research participants/family therapists. The opening reflexive questions will be guided by the *phenomenology* mode of inquiry.

To move into Consultation Model:

Overarching Aims of Consultation Model:

I. To externalise the internal dialogical activity of the therapist with the aim to trace the internal positions, the emerging positions, the presence of flexibility, inflexibility, and

position dominance and submission in response to a stuck phase i.e. to explicate the cognitive profile and cognitive mechanism therapist in response to therapeutic encounter.

II. To move towards the development of a non-hierarchal cluster of dialogical channels that assist in creating and maintaining an open, multi-positioned dialogue.

III. To gain insight into the organisation of the self and into the dialogue that takes place within the self; this process although reflective of point 1 and 2, moves towards the exposure of the self and subsequent examination of the self and enhanced understanding of self in relation to therapeutic encounter.

Consultation Model:

Pre-Consultative Model exploratory dialogue:

Task:

To understand how the therapist experiences a stuck phase in therapy.

Explore with participant how they would generally approach a stuck episode.

Researcher to introduce the dialogical approach to a stuck episode and request participant to partake in consultation influenced by dialogical theories.

Tasks:

Dialogical Model to be introduced to participating therapist: Hermans [2008] ideas of positions and voices to be aligned with characters in a play entering the stage at different points.

Inform participants that notes will be taken with focused reference towards mapping the Position Statements: This task is to enable the participant to view and track the statements, to track changes of perspective etc.

Opening question:

Aim: To understand how the therapist experiences a stuck phase in therapy.

Opening Dialogue:

1. "How do you experience a phase in therapy when you are stuck?"

To move into the Consultative Model as framed by the Dialogical perspective:

1st Phase:

Aim: To commence understanding the semiotic movement towards the stuck phase. [To remain within the therapist lens throughout consultation]:

Opening Dialogue: Researcher requests participant to describe the stuck phase that they are encountering:

2. "Let us look at the therapy process...when you sit with the client group that you have identified what do you observe, notice, feel and experience?"

[Aim of this mode of question i.e. phenomenological framed, is to shift description of client group from clinical description to a description that fits with dialogical and phenomenological epistemology and thereby provide a more holistic description].

Progress dialogue into understanding the semiotic movement towards the stuck phase:

3. "When did you notice stuckness?"
4. "How did you notice that you were moving into a stuck situation?"
5. "How was this experience different from a period in therapy that you felt there was movement?"

Position Statement: The Initial Evaluation: The task is to establish an *initial position* towards the stuck phase: The participant is requested to formulate a specific personal sentence that will refer to their *initial position*: [This statement aims to support the therapist to move towards a meta-position or executive position as described by Stiles [1999] and Rober et al [2008a]:

"How can you **now** describe the stuck phase?"

2nd Phase:

Aim: To begin externalising the internal semiotic process of the therapist as they are experiencing the stuck phase and to re-evaluate the *initial position* towards the stuck phase: Opening dialogue. Researcher requests participant to identify the positions or voices from which they frame the stuck experience e.g. theoretical or experiencing frame: Questions that assist in eliciting internal dialogue:

Professional and theoretical domain [potential to elicit pre-assumptions]:

1. "What theoretical questions arose?"
2. "What professional questions arose?"

3. "What dominant ideas did you have?"[Potential to further elicit dominant professional and theoretical positions].
4. "Where do these voices come from?
5. "What secondary ideas did you have?"[Potential to elicit further theoretical positions, with the aim to enrich dialogue or highlight adherence to professional or theoretical position]

Experiencing domain:

1. "What questions did you pose to your-self?"[Potential to elicit self-experiencing, hunches, instinctual and emotive positions].
2. "What hunches did you experience?"[As per question 5 aim].
3. "What feelings or emotions emerged?"
4. "Where do these voices come from? [E.g. Historical, social and experiencing; here-and-now voice; inchoate voice or unknown?]. Briefly describe the story behind each voice.

2nd Position Statement: A re-evaluation of established *initial position* towards the stuck phase: The participant is requested to re-formulate personal sentence:

"How can you *now* describe the stuck phase?"

3rd Phase:

Aim: Enactment of internal dialogues as drawn from the ideas of the dialogical–self theories and the ideas of Rober [1999, 2005b] and Rober et al [2008a; 2008b]: Participant requested to further explicate the semiotic process and to explicate the relationship/tension between positions as evoked by therapeutic encounter i.e. to look at stuck phase through alternative frames or alternative internal positions and compare; and, subsequently to expand on the re-evaluation of *initial position* e.g. questions:

1. "What would your professional or theoretical self say about the problem?"
2. "What are these voices telling you to look at?"
3. "What would your experiencing-self say to you about the problem?"
4. "What is your experiencing self-telling you to look at?"
5. "What are your experiences telling you to do?"
6. "Did any of your ideas or hunches surprise you?"
7. "Did any of your ideas or hunches perturb you?"

8. "Are these feelings, hunches and ideas familiar?"
9. "Are any of the ideas, feelings or hunches unfamiliar?"
10. "What is your theoretical self-telling you about your experiences?"
11. "Is this client group evoking positions that you do not normally utilise?" [With the aim to elicit the potential for the influence of particular family stories, presentations, idiosyncratic positions or voices as manifested by the family that may evoke therapist prejudices etc.].
12. "If so, is this process uncomfortable, or is it comfortable?"
13. "What questions do you think you could ask?" [To move semiotic process towards a reflexive position].
14. "What questions have you not asked so far?"[As question 15].

4th Phase:

3rd Position Statement: [3rd evaluation]: Participant requested to refer to *initial position/ and re-evaluation position* and explore; to reflect on developed expanded and alternative positions, and to explore if these positions would alter the *initial position:*

"How can you *now* describe the stuck phase?"

5th Phase:

Aim: To trace chain of dialogical patterns and semiotic development or movement:

To further explicate the emergent internal positions [to look at dominance, warded off positions, neglected aspects, flexibility, openness and multiplicity], the relationship between internal positions, to explicate the semiotic process and establish if there is a fragmented development i.e. meaning bridges between positions are not evolving or evolved [see Stiles, 1999]; the influence of repetitiveness, innovation and the potential introduction of movement through *relationship and correlation exposure*: The researcher will present the following questions:

When we explore the stuck experience:

1. "What voice is the strongest?"
2. "What voices are in the background?"
3. "What are these voices in the background telling you to do?"
4. "Do the voices like each other?"
5. "Do the voices dislike each other?"

6. "Do the dominant and minor voices tell you to ignore other voices?"
7. "Do the dominant or minor voices tell you to listen to other voices?"
8. "Do any voices surprise you?"
9. "Do any of these voices prompt or evoke other voices that you had forgotten about" [*Aim: to trace chain of dialogical patterns and semiotic development or movement]*

6th Phase:

Aim: Evaluation:

Up to this phase of interview the cognitive profile and cognitive mechanisms have been, [it is hoped by the model questions], illuminated. The following phase brings together the cognitive profile, cognitive mechanisms, and in link, experiencing-self; and further explicates the relationship between each category with the aim to trigger further reflection:

1. "When you move through your internal dialogue are there any surprises?"
2. "Will you introduce some of the ideas into the therapeutic process?"
3. "Or will some of the ideas influence the therapeutic process?"
4. "Has this process influenced how you understand you're *self?*"
5. "Has this process influenced how you understand the client group?"
6. "Has this process altered the way you may sit with the client group?"

Position Statement: 4th Evaluation: Request participant to look at *initial position and re-evaluations* and consider would they revise their position.

Draft 3: Post 1st Interview Format: Consultation 2:

Introduction to Dialogical lens and Consultation Model:

Aim of Consultation:

To stimulate reflexive thought about a stuck phase with research participants. The opening reflexive questions will be guided by the *phenomenology* mode of inquiry.

To move into Consultation Model:

Overarching Aims of Consultation Model:

1. To externalise the internal dialogical activity of the therapist with the aim to explicate what the therapist brings to the therapeutic encounter [cognitive profile], how they respond to the therapeutic encounter [cognitive mechanism] and in correlation, how they experience the therapeutic encounter.

2. To move towards the development of a non-hierarchal cluster of dialogical channels that assist in creating and maintaining an open, multi-positioned dialogue.
3. To gain insight into how the therapist positions themselves in relation to the identified client group through the exploration of the internal dialogue. This process although reflective of point 1 and 2, moves towards an enhanced understanding of the self in relation to therapeutic encounter and moves the therapist towards the development of a meta-reflexive position.

Pre-Consultative Model exploratory dialogue:

Task:

To understand how the therapist experiences a stuck phase in therapy.

Explore with participant how they would generally approach a stuck episode.

Researcher to introduce the dialogical approach to a stuck episode and request participant to partake in consultation influenced by dialogical theories.

Tasks:

1. Dialogical Model to be introduced to participating therapist: Hermans [2006] ideas of dialogical positions to be aligned with characters in a play entering the stage at different points.
2. To explain to participants the meaning of the professional self, the theoretical self, and the experiencing self. This discussion will assist the participants to understand the model questions and respond to model questions in a manner that facilitates their own reflection in relation to the stuck encounter.
3. Inform participants that notes will be taken with focused reference towards mapping the *Position Statements*: this task is to enable the participant to view and track the statements, to track changes of perspective, and to aid the development of a meta-reflexive position in relation to the stuck encounter.

Question:

Aim: To understand how the therapist experiences a stuck phase in therapy. The question is moulded by the phenomenological perspective. The aim is to prompt a description that brings into focus the experiencing elements and the self-narratives of the therapist.

Opening Dialogue:

"How do you experience a phase in therapy when you are stuck?"

To move into the Consultative Model as framed by the dialogical perspective:

The Dialogical Consultative Model:

1st Phase:

Aim: To commence understanding the dialogical movement towards the stuck phase. [To remain within the therapist lens throughout interview]:

Opening Dialogue: Researcher requests participant to describe the stuck phase that they are encountering:

1. "Let us look at the therapy process...when you sit with the client group that you have identified what do you observe, notice, feel and experience?"

Aim of this mode of question i.e. phenomenological framed, is to shift description of client group from clinical description to a description that fits with dialogical and phenomenological epistemology and thereby provide a more holistic description.

Progress dialogue into understanding the dialogical movement towards the stuck phase. This opening phase aims to prompt the therapist to describe how they understand a stuck phase.

2. "When did you notice stuckness?"
3. "How did you notice that you were moving into a stuck situation?"
4. "How was this experience different from a period in therapy that you felt there was movement?"

2nd Phase:

The Position Statement: The Initial Evaluation: The task is to establish an *initial position* towards the stuck phase: The participant is requested to formulate a specific personal sentence that will refer to their *initial position*. This statement aims to support the therapist to move towards a meta-position or executive position:

"How can you *now* describe the stuck phase?"

3rd Phase:

Aim: To begin externalising the internal dialogical process of the therapist as they are experiencing the stuck phase and to re-evaluate the initial position towards the stuck phase:

Opening dialogue. Researcher requests participant to identify the positions or voices from which they frame the stuck experience.

Questions that assist in eliciting internal dialogue:

Professional and theoretical domain [potential to elicit pre-assumptions]:

When you began to observe that you moved into a stuck phase what...

1. "What theoretical questions arose?"
2. "What professional questions arose?"
3. "What dominant ideas did you have?"[Potential to further elicit dominant professional and theoretical positions]
4. "Where do these ideas come from?
5. "What secondary ideas did you have?"[Potential to elicit further theoretical positions, with the aim to enrich dialogue or highlight adherence to professional or theoretical position].

Experiencing domain:

When you began to observe that you moved into a stuck phase what...

1. "What hunches did you experience?"[Potential to elicit self-experiencing, hunches, instinctual, emotive and the covert positions].
2. "What feelings or emotions emerged?"
3. "Where do these feelings, emotions or ideas come from? *[E.g. Historical, social and experiencing; here-and-now voice; inchoate voice, unknown?]*. Briefly describe the story behind each voice.
4. "What are these hunches, feelings, emotions telling you to do?"
5. "What questions did you pose to your-self?" [Potential to further elicit self-experiencing, hunches, instinctual, and emotive positions and potential to elicit reasoning or negotiating strategies between professional/ theoretical and experiencing positions].

4th Phase:

Position Statement: 2nd re-evaluation of established *initial position* towards the stuck phase: The participant is requested to re-formulate personal sentence:

"How can you *now* describe the stuck phase?"

5th Phase:

Aim: Enactment of internal dialogues as drawn from the ideas of the dialogical–self theories and the ideas of Rober [1999; 2008a; 2008b, 2008c] and Rober et al [2008a, 2008b]:

Participant requested to further explicate the semiotic process and to explicate the relationship/tension between positions as evoked by therapeutic encounter i.e. to look at stuck phase through alternative frames or alternative internal positions and compare; and, subsequently to expand on the re-evaluation of *initial position* e.g. questions. This phase will aim to prompt the move towards a meta-reflexive position:

1. "What would your professional or theoretical self say about the stuck phase?"
2. "What are these voices telling you to look at?"
3. "What would your instinctual self or experiencing self say to you about the stuck phase?"
4. "What is your experiencing self-telling you to look at?"
5. "What are your experiences telling you to do?"
6. "Did any of your ideas or hunches surprise you?"
7. "Did any of your ideas or hunches perturb you?"
8. "Are these feelings, hunches and ideas familiar?"
9. "Are any of the ideas, feelings or hunches unfamiliar?"
10. "What is your theoretical self-telling you about your experiences?"
11. "Is this client group evoking positions that you do not normally utilise?" [With the aim to elicit the potential for the influence of particular family stories, presentations, idiosyncratic positions or positions as manifested by the family that may evoke therapist prejudices etc.].
12. "If so, is this process uncomfortable, or is it comfortable?"
13. "What questions do you think you could ask?" [To move dialogical process towards a reflexive position].
14. "What questions have you not asked so far?"[As question 15].

6th Phase:

Position Statement: 3rd Re-evaluation: Participant requested to refer to *initial position/ and re-evaluation position* and explore; to reflect on developed expanded and alternative positions, and to explore if these positions would alter the *initial position:*

"How can you *now* describe the stuck phase?"

7th Phase:

Aim: To trace chain of dialogical patterns and dialogical development or movement:

To further explicate the emergent internal positions [to look at dominance, warded off positions, neglected aspects, flexibility, openness and multiplicity], the symbiotic relationship between internal positions, to explicate the semiotic process and establish if there is a fragmented development i.e. meaning bridges between positions are not evolving or evolved [Stiles, 1999]; the influence of repetitiveness, innovation and the potential introduction of movement through the development of meaning bridges between dialogical channels. Again, this process aims to prompt the therapist to further develop a meta-reflexive position.

The researcher will present the following questions:

When we explore the stuck experience:

1. "What voice is the strongest?"
2. "What voices are in the background?"
3. "What are these voices in the background telling you to do?"
4. "Do the voices like each other?"
5. "Do the voices dislike each other?"
6. "Do the dominant and minor voices tell you to ignore other voices?"
7. "Do the dominant or minor voices tell you to listen to other voices?"
8. "Do any voices surprise you?"
9. "Do any of these voices prompt or evoke other voices that you had forgotten about" [*Aim: to trace chain of dialogical patterns and semiotic development or movement]*.

<u>8th Phase:</u>

Evaluation:

Up to this phase of interview the cognitive profile and cognitive mechanisms have been, [it is hoped by the model questions], illuminated. The following phase brings together the cognitive profile, cognitive mechanisms, and in link, experiencing-self; and further explicates the relationship between each category with the aim to trigger further reflection with again a prompt to develop a meta reflexive perspective:

1. "When you move through your internal dialogue are there any surprises?"
2. "Will you introduce some of the ideas into the therapeutic process?"
3. "Or will some of the ideas influence the therapeutic process?"
4. "Has this process influenced how you understand you're self?"
5. "Has this process influenced how you understand the client group?"
6. "Has this process altered the way you may sit with the client group?"

4th Evaluation: Request participant to look at initial position and re-evaluations and consider would they revise their position.

Draft 4: Post 2nd Consultation Format:
[This draft is for use in Consultation 3]:

Aim of Interview: Introduction to Dialogical lens and Consultation Model:

To stimulate reflexive thought about a stuck phase with research participants. The opening reflexive questions will be guided by the *phenomenology* mode of inquiry.
To move into Consultation Model:
Overarching Aims of Consultation Model:

1. To externalise the internal dialogical activity of the therapist with the aim to explicate what the therapist brings to the therapeutic encounter [cognitive profile], how they respond to the therapeutic encounter [cognitive mechanism] and in correlation, how they experience the therapeutic encounter.
2. To move towards the development of a non-hierarchal cluster of dialogical channels that assist in creating and maintaining an open, multi-positioned dialogue.
3. To gain insight into how the therapist positions themselves in relation to the identified client group through the exploration of the internal dialogue. This process although reflective of point 1 and 2, moves towards an enhanced understanding of the self in relation to therapeutic encounter and moves the therapist towards the development of a meta-reflexive position.
4. The development of a meta position which enables the therapist to view all voices, their relationships in a more receptive environment, with the aim to work towards a community of linked voices, or in systemic terms, linked ideas, thoughts and observations that will create a multiplicity of thought and a flexible perspective to family or client group stories and dynamics.

Interview and Consultation Model:

Pre-Consultative Model exploratory dialogue:
Task:
To understand how the therapist experiences a stuck phase in therapy.
Explore with participant how they would generally approach a stuck episode.

Researcher to introduce the dialogical approach to a stuck episode and request participant to partake in consultation influenced by dialogical theories.

Tasks:

1. Dialogical Model to be introduced to participating therapist: Hermans [2008] ideas of dialogical positions to be aligned with characters in a play entering the stage at different points [see chapter 4].
2. To explain to participants the meaning of the professional self, the theoretical self, and the experiencing self. This discussion will assist the participants to understand the model questions and respond to model questions in a manner that facilitates their own reflection in relation to the stuck encounter.
3. Inform participants that notes will be taken with focused reference towards mapping the *Position Statements*: this task is to enable the participant to view and track the statements, to track changes of perspective, and to aid the development of a meta-reflexive position in relation to the stuck encounter.

Question:

Aim: To understand how the therapist experiences a stuck phase in therapy. The phenomenological perspective moulds the question. The aim is to prompt a description that brings into focus the experiencing elements and the self-narratives of the therapist.

Opening Dialogue:

"How do you experience a phase in therapy when you are stuck?"

To move into the Consultative Model as framed by the dialogical perspective:

The Dialogical Consultative Model:

1st Phase:

Aim: To commence understanding *the dialogical movement towards* [selected highlight] the stuck phase. [To remain within the therapist lens throughout interview]:

Opening Dialogue: Researcher requests participant to describe the stuck phase that they are encountering:

1. "Let us look at the therapy process...when you sit with the client group that you have identified what do you observe, notice, feel and experience?" [Aim of this mode of question i.e. phenomenological framed, is to shift description of client group from clinical description to a description that fits with dialogical and phenomenological epistemology and thereby provide a more holistic description].

Progress dialogue into understanding the dialogical movement towards the stuck phase. This opening phase aims to prompt the therapist to describe how they understand a stuck phase.

2. "When did you notice stuckness?"
3. "How did you notice that you were moving into a stuck situation?"
4. "How was this experience different from a period in therapy that you felt there was movement?"

2nd Phase:

The Position Statement: The Initial Evaluation: The task is to establish an *initial position* towards the stuck phase: The participant is requested to formulate a specific personal sentence that will refer to their *initial position*: [This statement aims to support the therapist to move towards a meta-position or executive position as described by Stiles [1999], Rober [2008a]:

"How can you *now* describe how you understand or observe the stuck phase?"

3rd Phase:

Aim: To begin externalising the internal dialogical process of the therapist as they are *experiencing the stuck phase* and to re-evaluate the *initial position* towards the stuck phase:

Opening dialogue. Researcher requests participant to identify the positions or voices from which they frame the stuck experience e.g. theoretical or experiencing frame: Questions that assist in eliciting internal dialogue:

Professional and theoretical domain [potential to elicit pre-assumptions]:

When you began to observe that you moved into a stuck phase what...

1. "What theoretical questions arose?"
2. "What professional questions arose?"
3. "What dominant ideas did you have?"[Potential to further elicit dominant professional and theoretical positions].
4. "Where do these ideas come from?
5. "What secondary ideas did you have?"[Potential to elicit further theoretical positions, with the aim to enrich dialogue or highlight adherence to professional or theoretical position].

Experiencing domain:

When you began to observe that you moved into a stuck phase what...

1. "What hunches did you experience?"

2. "What feelings or emotions emerged?"
3. "Where do these feelings, emotions or ideas come from? *[E.g. Historical, social and experiencing; here-and-now voice; inchoate voice, unknown?]*. Briefly describe the story behind each voice.
4. "What are these hunches, feelings, emotions telling you to do?"
5. "What questions did you pose to your-self?" [Potential to further elicit self-experiencing, hunches, instinctual, and emotive positions and potential to elicit reasoning or negotiating strategies between professional/ theoretical and experiencing positions].

4th Phase:

Position Statement: A re-evaluation of established *initial position* towards the stuck phase: The participant is requested to re-formulate personal sentence:

"If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation to the stuck experience that you introduced?"

5th Phase:

Aim: Enactment of internal dialogues as drawn from the ideas of the dialogical–self theories and the ideas of Rober [1999; 2008a; 2008b, 2008c] and Rober et al [2008a, 2008b]: Participant requested to further explicate the semiotic process and to explicate the relationship/tension between positions as evoked by therapeutic encounter i.e. to look at stuck phase through alternative frames or alternative internal positions and compare; and, subsequently to expand on the re-evaluation of *initial position* e.g. questions. This phase will aim to prompt the move towards a meta-reflexive position:

1. "What would your professional or theoretical self say about the stuck phase?" And, [1a] "What are these voices telling you to look at?"
2. "What would your instinctual self or experiencing self say to you about the stuck phase?"
3. "What is your experiencing self-telling you to look at?"
4. "What are your experiences telling you to do?"
5. "Did any of your ideas or hunches surprise you?"
6. **"**Did any of your ideas or hunches perturb you?"
7. "Are these feelings, hunches and ideas familiar?"

8. “Are any of the ideas, feelings or hunches unfamiliar?”
9. “What is your theoretical self-telling you about your experiences?”
10. “Is this client group evoking positions that you do not normally utilise?” [With the aim to elicit the potential for the influence of particular family stories, presentations, idiosyncratic positions or positions as manifested by the family that may evoke therapist prejudices etc.].
11. “If so, is this process uncomfortable, or is it comfortable?”
12. “What questions do you think you could ask?” [To move dialogical process towards a reflexive position].
13. “What questions have you not asked so far”

6th Phase:

Position Statement: 3rd Re-evaluation: Participant requested to refer to *initial position/ and re-evaluation position* and explore; to reflect on developed expanded and alternative positions, and to explore if these positions would alter the *initial position:*

> “If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation to the stuck experience and the client group that you introduced?”

7th Phase:

Aim: To trace chain of dialogical patterns and dialogical development or movement:

To further explicate the emergent internal positions [to look at dominance, warded off positions, neglected aspects, flexibility, openness and multiplicity], the symbiotic relationship between internal positions, to explicate the semiotic process and establish if there is a fragmented development i.e. meaning bridges between positions are not evolving or evolved [Stiles, 1999]; the influence of repetitiveness, innovation and the potential introduction of movement through the development of meaning bridges between dialogical channels. Again, this process aims to prompt the therapist to further develop a meta-reflexive position.

The researcher will present the following questions:

When we explore the stuck experience:

1. “What voice is the strongest?”
2. “What voices are in the background?”
3. “What are these voices in the background telling you to do?”

4. "Do the voices like each other?"
5. "Do the voices dislike each other?"
6. "Do the dominant and minor voices tell you to ignore other voices?"
7. "Do the dominant or minor voices tell you to listen to other voices?"
8. "Do any voices surprise you?"
9. "Do any of these voices prompt or evoke other voices that you had forgotten about" [*Aim: to trace chain of dialogical patterns and movement]*.

8th Phase:

Evaluation:

Up to this phase of interview the cognitive profile and cognitive mechanisms have been, [it is hoped by the model questions], illuminated. The following phase brings together the cognitive profile, cognitive mechanisms, and in link, experiencing-self; and further explicates the relationship between each category with the aim to trigger further reflection with again a prompt to develop a meta reflexive perspective:

1. "When you move through your internal dialogue are there any surprises?"
2. "Will you introduce some of the ideas into the therapeutic process?"
3. "Or will some of the ideas influence the therapeutic process?"
4. "Has this process influenced how you understand you're self?"
5. "Has this process influenced how you understand the client group?"
6. "Has this process altered the way you may sit with the client group?"

4th Evaluation: Request participant to look at *initial position and re-evaluations* and consider would they revise their position.

> "If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation to the stuck experience and the client group that you introduced?"

Draft 5: [Post 3rd consultation format]

This draft is for use in Consultation 4:

Consultation Four:

Aim of Interview: Introduction to Dialogical lens and Consultation Model:

To stimulate reflexive thought about a stuck phase with research participants. The opening reflexive questions will be guided by the *phenomenology* mode of inquiry.

To move into Consultation Model:

Overarching Aims of Consultation Model:

1. To externalise the internal dialogical activity of the therapist with the aim to explicate what the therapist brings to the therapeutic encounter [cognitive profile], how they respond to the therapeutic encounter [cognitive mechanism] and in correlation, how they experience the therapeutic encounter.
2. To move towards the development of a non-hierarchal cluster of dialogical voices that assist in creating and maintaining an open, multi-positioned dialogue.
3. To gain insight into how the therapist positions themselves in relation to the identified client group through the exploration of the internal dialogue. This process although reflective of point 1 and 2, moves towards an enhanced understanding of the self in relation to therapeutic encounter.
4. The development of a meta position, as developed through the externalising of the community of internal voices, which enables the therapist to view all voices, their relationships in a more transparent environment, with the aim to work towards a community of linked voices, or in systemic terms, linked ideas, thoughts and observations that will create a multiplicity of thought and a flexible perspective to family or client group stories and dynamics.

Interview and Consultation Model:

Pre-Consultative Model exploratory dialogue:

Task:

To understand how the therapist experiences a stuck phase in therapy.

Explore with participant how they would generally approach a stuck episode.

Researcher to introduce the dialogical approach to a stuck episode and request participant to partake in consultation influenced by dialogical theories.

Tasks:

1. Dialogical Model to be introduced to participating therapist: Hermans [2008] ideas of dialogical positions to be aligned with characters in a play entering the stage at different points [see chapter 4].

2. To explain to participants the meaning of: the professional self, the theoretical self or the systemic self, and the experiencing self. This discussion will assist the participants to understand the model questions and respond to model questions in a manner that facilitates their own reflection in relation to the stuck encounter.
3. Inform participants that notes will be taken with focused reference towards mapping the *Position Statements*: this task is to enable the participant to view and track the statements, to track changes of perspective, and to aid the development of a meta-reflexive position in relation to the stuck encounter.

Opening question:

Aim: To understand how the therapist experiences a stuck phase in therapy. The question is moulded by the phenomenological perspective. The aim is to prompt a description that brings into focus the experiencing elements and the self-narratives of the therapist.

Opening Dialogue:

"How do you experience a phase in therapy when you are stuck?"

To move into the Consultative Model as framed by the dialogical perspective:

The Dialogical Consultative Model:

1st Phase:

Aim: To commence understanding *the dialogical movement towards* [selected highlight] the stuck phase.

Opening Dialogue: Researcher requests participant to describe the stuck phase that they are encountering:

1. "Let us look at the therapy process...when you sit with the client group that you have identified what do you observe?" [Aim of this mode of question i.e. phenomenological framed, is to shift description of client group from clinical description to a description that fits with a dialogical, phenomenological and Gadamerian epistemology and thereby provide a more holistic description].
2. What is it like to sit with this family and hear their stories? This question has been introduced at Consultation 4: Its aim is threefold, to further thicken a phenomenological description, to elucidate further the experiencing-self and thus to bring into focus the therapist as an active participant.

Progress dialogue into understanding the dialogical movement towards the stuck phase. This opening phase aims to prompt the therapist to describe how they understand a stuck phase.

1. "How did you notice that you were moving into a stuck situation?"[72]
2. "How was this experience different from a period in therapy that you felt there was movement?"

2nd Phase:

The Position Statement: The Initial Evaluation: The task is to establish an *initial position* towards the stuck phase: The participant is requested to formulate a specific personal sentence or reflections that will refer to their *initial position*: [This statement aims to support the therapist to move towards a meta-position:

"How can you now describe how you understand or observe the stuck phase?"

3rd Phase:

Aim: To begin externalising the internal dialogical process of the therapist as they are *experiencing the stuck phase* and to re-evaluate the *initial position* towards the stuck phase:

Opening dialogue. Researcher requests participant to identify the positions or voices from which they frame the stuck experience.

Questions that assist in eliciting internal dialogue:

Professional and systemic domain [potential to elicit pre-assumptions]:

When you began to observe that you moved into a stuck phase what...

1. "What systemic questions arose?"
2. "What professional questions arose?"
3. "What dominant ideas did you have?"[Potential to further elicit dominant professional and theoretical positions].
4. "Where do these ideas come from?
5. "Are you conscious of a professional or systemic voice in the background?"[73]

Experiencing domain:

When you began to observe that you moved into a stuck phase what...

1. "What hunches did you experience?"[Potential to elicit self-experiencing and emotive positions]

[72]"When did you notice stuckness?" this question [question 3] was removed before consultation 4 in that I felt it was repetitive.

[73]This question was added in format 4.

2. "With the hunches, what feelings or emotions emerged?"
3. "Where do these feelings, emotions or ideas come from? *[E.g. Historical, social and experiencing; here-and-now voice; inchoate voice, unknown?]*. Briefly describe the story behind each voice.
4. "What are these hunches, feelings, emotions telling you to do?"
5. "With these hunches, what questions did you pose to your-self?" [Potential to further elicit self-experiencing, hunches, instinctual, and emotive positions and potential to elicit reasoning or negotiating strategies between professional/ theoretical and experiencing positions].

"Are you conscious of a hunch in the background or emerging in the background?"

4th Phase:

Position Statement: A re-evaluation of established *initial position* towards the stuck phase: The participant is requested to re-formulate personal sentence:

> "If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation to the stuck experience that you introduced?"

5th Phase:

Aim: Enactment of internal dialogues as drawn from the ideas of the dialogical–self theories and the ideas of Rober [1999; 2008a; 2008b, 2008c] and Rober et al [2008a, 2008b]: Participant requested to further explicate the semiotic process and to explicate the relationship/tension between voices as evoked by therapeutic encounter i.e. to look at stuck phase through alternative frames or alternative internal positions and compare; and, subsequently to expand on the re-evaluation of *initial position*. This phase will aim to prompt the move towards a meta-reflexive position:

1. "What would your professional or systemic self say about the stuck phase?"[74]

[74]These questions have been deleted as I feel they are repetitive: [1a] "What are these voices telling you to look at?" and [7] "What is your theoretical self-telling you about your hunches or experiences?"

2. “What would your instinctual self or your hunches say to you about the stuck phase?” [prompts: What are your hunches or experiencing self-telling you to look at?”; “What are your hunches or experiences telling you to do?”]
3. “Did any of your hunches surprise you?”
4. “Did any of your hunches perturb you?”
5. “Are these feelings, hunches and ideas familiar?”
6. “Are any of the ideas, feelings or hunches unfamiliar?”
7. “Is this client group evoking positions that you do not normally utilise?” [With the aim to elicit the potential for the influence of particular family stories, presentations, idiosyncratic positions or positions as manifested by the family that may evoke therapist prejudices etc.].
8. “If so, is this process uncomfortable, or is it comfortable?”
9. “What questions do you think you could ask?” [To move dialogical process towards a reflexive meta-position].
10. “What questions have you not asked so far?”

6th Phase:

Position Statement: Third Evaluation: Participant requested to refer to *initial position/ and re-evaluation position* and explore; to reflect on developed expanded and alternative positions, and to explore if these positions would alter the *initial position:*

> “If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation to the stuck experience and the client group that you introduced?”

7th Phase:

Aim: To trace chain of dialogical patterns and dialogical development or movement:

To further explicate the emergent internal positions [to look at dominance, warded off positions, neglected aspects, flexibility, openness and multiplicity], the symbiotic relationship between internal positions, to explicate the semiotic process and establish if there is a fragmented development i.e. meaning bridges between positions are not evolving or evolved [Stiles, 1999]; the influence of repetitiveness, innovation and the potential introduction of movement through the development of meaning bridges between dialogical channels. Again, this process aims to prompt the therapist to further develop a meta-reflexive position.

The researcher will present the following questions:

Let us reflect back on the stage idea [Hermans, 2008][75]…When we explore the stuck experience:

1. "What ideas or hunches are centre stage or the strongest?"
2. "What ideas or hunches are in the background?" [Prompts: "What are these voices in the background telling you to do?"; "Do the voices like each other?"; "Do the voices dislike each other? "Do the dominant and minor voices tell you to ignore other voices?"; "Do the dominant or minor voices tell you to listen to other voices?"]
3. "Do any of these voices, ideas or hunches prompt or evoke other ideas or experiences that you had forgotten about" [*Aim: to trace chain of dialogical patterns and semiotic development or movement] [prompt:* "Do any voices surprise you?"]

8th Phase:

Evaluation:

Up to this phase of interview the cognitive profile and cognitive mechanisms have been illuminated. The following phase brings together the cognitive profile, cognitive mechanisms, and in link, experiencing-self; and further explicates the relationship between each category with the aim to trigger further reflection with again a prompt to develop a meta-reflexive perspective:

1. "When you move through your thoughts, ideas and reflections are there any surprises?"
2. "As we stepped through your thoughts and reflections has this influenced how you see or understand you're self?"
3. "Or has it influenced the way you observe or relate to the client group?"
4. "When we put our thoughts and observations together ….has this process altered the way you may sit with the client group?"[76]

4th Evaluation: Request participant to look at *initial position and re-evaluations* and consider would they revise their position:

[75]This note has been added to assist understanding [format 4].

[76]These questions have been altered in order to develop a more phenomenological and Gadamerian lens. It will be a trial and error for the next interview.

"If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation to the stuck experience and the client group that you introduced?"

Draft 5 amended: This draft is for use in Consultation 4:

Draft 5a has been amended in light of limited time. This activity has prompted a shift from cognitive to dialogical perspective and in doing so addressed my prejudices:

Draft 5b: Consultation 4:

Aim of Interview: Introduction to Dialogical lens and Consultation Model:

To stimulate reflexive thought about a stuck phase with research participants. The opening reflexive questions will be guided by the *phenomenology* mode of inquiry.

To move into Consultation Model:

Overarching Aims of Consultation Model:

1. To externalise the internal dialogical activity of the therapist with the aim to explicate what the therapist brings to the therapeutic encounter [cognitive profile], how they respond to the therapeutic encounter [cognitive mechanism] and in correlation, how they experience the therapeutic encounter.
2. To move towards the development of a non-hierarchal cluster of dialogical voices that assist in creating and maintaining an open, multi-positioned dialogue.
3. To gain insight into how the therapist positions themselves in relation to the identified client group through the exploration of the internal dialogue. This process although reflective of point 1 and 2, moves towards an enhanced understanding of the self in relation to therapeutic encounter.
4. The development of a meta position, as developed through the externalising of the community of internal voices, which enables the therapist to view all voices, their relationships in a more transparent environment, with the aim to work towards a community of linked voices, or in systemic terms, linked ideas, thoughts and

observations that will create a multiplicity of thought and a flexible perspective to family or client group stories and dynamics.

Interview and Consultation Model:

Pre-Consultative Model exploratory dialogue:

Task:

To understand how the therapist experiences a stuck phase in therapy.

Researcher to introduce the dialogical approach to a stuck episode and request participant to partake in consultation influenced by dialogical theories.

Tasks:

1. The Dialogical Model to be introduced to participating therapist: Hermans [2006] ideas of dialogical positions to be aligned with characters in a play entering the stage at different points.
2. To explain to participants the meaning of the professional self, the theoretical self or the systemic self, and the experiencing self. This discussion will assist the participants to understand the model questions and respond to model questions in a manner that facilitates their own reflection in relation to the stuck encounter.
3. Inform participants that notes will be taken with focused reference towards mapping the *Position Statements*: this task is to enable the participant to view and track the statements, to track changes of perspective, and to aid the development of a meta-reflexive position in relation to the stuck encounter.

Opening question:

Aim: To understand how the therapist experiences a stuck phase in therapy. The question is moulded by the phenomenological perspective. The aim is to prompt a description that brings into focus the experiencing elements and the self-narratives of the therapist.

Opening Dialogue:

"How do you experience a phase in therapy when you are stuck?"

To move into the Consultative Model as framed by the dialogical perspective:

The Dialogical Consultative Model:

1st Phase:

Aim: To commence understanding *the dialogical movement towards* the stuck phase.

Opening Dialogue: Researcher requests participant to describe the stuck phase that they are encountering:

1. "Let us look at the therapy process...when you sit with the client group that you have identified what do you observe?"[77]

Aim of this mode of question i.e. phenomenological framed, is to shift description of client group from clinical description to a description that fits with a dialogical, phenomenological and Gadamerian epistemology and thereby provide a more holistic description.

2. "What is it like to sit with this family and hear their stories?"

This question has been introduced at Consultation 4: Its aim is threefold, to further thicken a phenomenological description, to elucidate further the experiencing-self and to bring into focus the therapist as an active participant.

Progress dialogue into understanding the dialogical movement towards the stuck phase. This opening phase aims to prompt the therapist to describe how they understand a stuck phase.

3. "We opened the interview with a look at how we can understand stuckness …with this family how did you notice that you were moving into a stuck situation?"

Prompt: How was this experience different from a period in therapy that you felt there was movement?[78]

<u>2nd Phase:</u>

<u>The Position Statement: The Initial Evaluation:</u> The task is to establish an *initial position* towards the stuck phase: The participant is requested to formulate a specific personal sentence or reflections that will refer to their *initial position*: [This statement aims to support the therapist to move towards a meta-position or executive position as described by Stiles [1999], Rober [2008a]:

"How can you now describe how you understand or observe the stuck phase?"

<u>3rd Phase:</u>

[77]Prior to this draft I had also included in this question: what do you notice, feel and experience i.e. I have removed these words, as I felt the question was too long and complex. However, I felt that it was important to continue inquiring about how they experience the family group and the stories that they share, so question two was added. It is hoped that it will produce a thicker description that brings into focus the therapist as an active, experiencing participant in the therapeutic process.

[78] Question 4 changed to prompt.

Aim: To begin externalising the internal dialogical process of the therapist as they are *experiencing the stuck phase* and to re-evaluate the *initial position* towards the stuck phase:

Opening dialogue. Researcher requests participant to identify the positions from which they frame the stuck experience.

Questions that assist in eliciting internal dialogue:

Professional and systemic domain [potential to elicit pre-assumptions]:

When you began to observe that you moved into a stuck phase what...

4. "What systemic ideas or questions arose?"
5. "What professional ideas or questions arose?"
6. "Are you conscious of another professional or systemic idea in the background?" Prompt: "Where do these ideas come from? Potential to elicit patterns of practice, bias and preferences[79].

Experiencing domain:

When you began to observe that you moved into a stuck phase what...

1. "What hunches did you experience?" Prompt: "With the hunches, did you experience any feelings or emotions?"
2. "Tell me a little bit about these hunches? Prompts: "Briefly describe the story behind each voice"; and or: "What are these hunches, feelings, emotions telling you to look at or do?"
3. "With these hunches, are they showing you something different about the family. Prompt: what questions did you pose to your-self?"[80] [*Potential to further elicit self-experiencing positions and potential to elicit reasoning or negotiating strategies between professional/ theoretical and experiencing positions]*.
4. "Are you conscious of a hunch in the background or emerging in the background?"

4th Phase:

Aim: Enactment of internal dialogues as drawn from the ideas of the dialogical–self theories and the ideas of Rober [1999; 2008a; 2008b, 2008c] and Rober et al [2008a, 2008b]. Participant requested to further explicate the internal dialogue and to explicate the relationship/tension between voices as evoked by therapeutic encounter i.e. to look at stuck

[79]Question 3 and 4 deleted with aim to prompt reflection rather than the participant having to reply to cognitive questions.

[80]This experiencing section has been amended with the aim to tidy it up in that the questions were long and cognitive in nature.

phase through alternative frames or alternative internal positions and compare. This phase will aim to prompt the move towards a meta-reflexive position:

1. "What is your professional or systemic-self saying about the stuck phase?"
2. "What are your hunches saying to you about the stuck phase?" Prompts: What are your hunches or experiencing self-telling you to look at?"; "What are your hunches or experiences telling you to do?"
3. "Did any of your hunches surprise you?"
4. "Did any of your hunches perturb you?"
5. "Are these feelings, hunches and ideas familiar?"
6. "Are any of the ideas, feelings or hunches unfamiliar?"
7. "Do any of these voices, ideas or hunches prompt or evoke other ideas or experiences that you had forgotten about"
8. "How are your systemic ideas fitting with your hunches?"[81]
9. "Is this client group evoking positions that you do not normally utilise?" [With the aim to elicit the potential for the influence of particular family stories, presentations, idiosyncratic positions or positions as manifested by the family that may evoke therapist prejudices etc.].
10. "If so, is this process uncomfortable, or is it comfortable?"
11. "What questions do you think you could ask?" [To move dialogical process towards a reflexive meta-position].
12. "What questions have you not asked so far?"

5th Phase:

Evaluation:

Up to this phase of interview the cognitive profile and cognitive mechanisms have been illuminated. The following phase brings together the cognitive profile, cognitive mechanisms, and in link, experiencing-self; and further explicates the relationship between each category with the aim to trigger further reflection with again a prompt to develop a meta-reflexive perspective:

1. "When you now move through your thoughts, ideas and reflections are there any changes or maybe surprises?"

[81]This question was rephrased from: "What is your theoretical self-telling you about your hunches or experiences".

2. "As we stepped through your thoughts and reflections has this influenced how you see or understand you're self?"
3. "Or has it influenced the way you may observe or relate to the client group at your next meeting?"
4. "When we put our thoughts and observations together ….has this process altered the way you may sit with the client group?"[82]

2nd Position Statement Evaluation:

Request participant to look at *initial position* and consider would they revise their position:

> "If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation to the stuck experience and the client group that you introduced?"

Draft 6: Post Format draft 5b

This draft is for use in consultation 5:

Consultation 5:

Aim of Interview: Introduction to Dialogical lens and Consultation Model:

To stimulate reflexive thought about a stuck phase with research participants. The opening reflexive questions will be guided by the *phenomenology* mode of inquiry.

To move into Consultation Model:

Overarching Aim of Consultation Model:

To externalise the internal dialogical activity of the therapist with the aim to explicate what the therapist brings to the therapeutic encounter [cognitive profile i.e. their historical ideas, reflections and experiences], how they experience the therapeutic encounter [i.e. their here-and-now experiences as emergent in the therapeutic activity] and how they participate and respond to the therapeutic encounter [cognitive mechanism] so as to gain new insights into their unique-self, how they position themselves in the therapeutic activity, how they observe the client group with a move towards a response building reflexive activity that brings

[82]These questions [i.e. 1, 2, 3, and 4] have been altered in order to develop a more phenomenological and Gadamerian lens. It will be a trial and error for the next interview.

together in an inclusive , welcoming environment all of their ideas and reflections with a direct interest and responsiveness towards all aspects of the family group, their narratives, insights and experiences [see Rogers, 1951, 41].[83]

To achieve this aim the dialogical model in practice aims to prompt the therapist to move through a number of reflexive activities:

1. To move towards the development of a non-hierarchal cluster of dialogical voices or in systemic terms, the articulation of all ideas, reflections and hunches that assist in creating and maintaining an open, multi-positioned dialogue.
2. To move the therapist towards an enhanced insight into how they positions themselves in relation to the identified client group through the exploration of the internal dialogue with emphasis on their experiencing reflections.
3. The development of a meta position or *observational position*, as developed through the externalising of the community of internal voices, which enables the therapist to view all voices or in systemic terms, all ideas, reflections and self-experiences, their relationships in a more transparent environment, with the aim to work towards a community of linked voices, or in systemic terms, linked ideas, thoughts and observations that will create a multiplicity of thought and a flexible perspective to family or client group stories and dynamics.
4. To support the therapist to move into a reflexive trajectory that encompasses 4 interconnected reflexive phases i.e. 1: the articulation and exploration of all reflections, ideas and experiences of self of the therapist; 2. A move towards an appreciation and welcoming of all ideas and seeing all as worthy with a Gadamerian movement between all observations, reflections and ideas; 3. An articulation of an interest in the family experiences, stories and emergent narratives and how they translate to the therapeutic encounter and how they *connect* with therapist's reflections and observations [empathic reflections]; 4. A move into an inclusive and response building reflexive activity [see Rober et al, 2008a].

<u>Interview and Consultation Model:</u>

Pre-Consultative Model exploratory dialogue:

Aim:

[83] Rogers, C.R [1951]. Client centred therapy. Boston, MA. Houghton Mifflin.

To understand how the therapist experiences a stuck phase in therapy.

Researcher to introduce the dialogical approach to a stuck episode and request participant to partake in consultation influenced by dialogical theories.

Introductory Tasks:

1. The Dialogical Model to be introduced to participating therapist: Hermans [2006] ideas of dialogical positions to be aligned with characters in a play entering the stage at different points.
2. To explain to participants the meaning of the professional-self, the systemic-self, and the experiencing-self. This discussion will assist the participants to understand the model questions and respond to model questions in a manner that facilitates their own reflection in relation to the stuck encounter.
3. Inform participants that notes will be taken with focused reference towards mapping the *Position Statements*: this task is to enable the participant to view and track the statements, to track changes of perspective, and to aid the development of a meta-reflexive position or observational position in relation to the stuck encounter.

Opening question:

Aim: To understand how the therapist experiences a stuck phase in therapy. The question is moulded by the phenomenological perspective. The aim is to prompt a description that brings into focus the experiencing self-narratives of the therapist.

Opening Dialogue:

"How do you experience a phase in therapy when you are stuck?"

To move into the Consultative Model as framed by the dialogical perspective:

The Dialogical Consultative Model:

1st Phase:

Aim: To commence understanding the dialogical movement towards the stuck phase:

Opening Dialogue: Researcher requests participant to describe the stuck phase that they are encountering:

1. "Let us look at the therapy process...when you sit with the client group that you have identified what do you observe?"

Aim of phenomenological framed question: To encourage a description that fits with a dialogical, phenomenological and Gadamerian epistemology and thereby provide a more holistic description].

2. "What is it like to sit with this family and hear their stories?"

Aim of this question is threefold: to further thicken a phenomenological description, to elucidate further the experiencing-self and to bring into focus the therapist as an active participant.

Progress dialogue into understanding the dialogical movement towards the stuck phase. This opening phase aims to prompt the therapist to describe how they understand a stuck phase.

3. "We opened the interview with a look at how we can understand stuckness …with this family how did you notice that you were moving into a stuck situation?"

Prompt: "How was this experience different from a period in therapy that you felt there was movement?"

2nd Phase:

The Position Statement: The Initial Evaluation: The task is to establish an *initial position* towards the stuck phase: The participant is requested to formulate a specific personal sentence or reflections that will refer to their *initial position*: [This statement aims to support the therapist to move towards a meta-position:

"How can you now describe how you understand or observe the stuck phase?"

3rd Phase:

Aim: To begin externalising the internal dialogical process of the therapist as they are *experiencing the stuck phase* and to re-evaluate the *initial position* towards the stuck phase:

Opening dialogue. Researcher requests participant to identify the positions or voices from which they frame the stuck experience e.g. theoretical, systemic or experiencing frame: Questions that assist in eliciting internal dialogue:

Professional and systemic domain [potential to elicit pre-assumptions]:

When you began to observe that you moved into a stuck phase what...

4. "What systemic ideas or questions arose?"
5. "What professional ideas or questions arose?"
6. "Are you conscious of another professional or systemic idea in the background?"

Experiencing domain:

When you began to observe that you moved into a stuck phase what...

1. "What hunches did you experience?" prompt: "With the hunches, did you experience any feelings or emotions?"
2. "Tell me a little bit about these hunches? Prompts: Briefly describe the story behind each voice; what are these hunches, feelings, emotions telling you to look at or do?"
3. "With these hunches, are they showing you something different about the family. Prompt: what questions did you pose to your-self?" Aim: Potential to further elicit self-experiencing and elicit reasoning or negotiating strategies between professional/ systemic and experiencing positions.
4. "Are you conscious of a hunch in the background or emerging in the background?"

4th Phase:

Aim: Enactment of internal dialogues as drawn from the ideas of the dialogical–self theories and the ideas of Rober [1999; 2008a; 2008b, 2008c] and Rober et al [2008a, 2008b]. Participant requested to further explicate the semiotic process and to explicate the relationship/tension between voices as evoked by therapeutic encounter i.e. to look at stuck phase through alternative frames or alternative internal positions and compare. This phase will aim to prompt the move towards a meta-reflexive position:

Let us bring together the ideas, reflections and hunches that you have spoke of:

1. "What is your professional or systemic-self saying about the stuck phase?"
2. "What are your hunches saying to you about the stuck phase?" prompts: What are your hunches or experiencing self-telling you to look at?"; "What are your hunches or experiences telling you to do?"
3. "Are these feelings, hunches and ideas familiar?"
4. "Are any of the ideas, feelings or hunches unfamiliar?" prompts: "Did any of your hunches surprise you?"; "Did any of your hunches perturb you?"
5. "Do any of these voices, ideas or hunches prompt or evoke other ideas or experiences that you had forgotten about"
6. "How are your systemic ideas fitting with your hunches?"[84]
7. "Is this client group evoking positions that you do not normally utilise?" [With the aim to elicit the potential for the influence of particular family stories, presentations,

[84]This question was rephrased from "What is your theoretical self-telling you about your hunches or experiences".

idiosyncratic positions or positions as manifested by the family that may evoke therapist prejudices etc.].

8. "If so, is this process uncomfortable, or is it comfortable?"
9. "What questions do you think you could ask?" [To move dialogical process towards a reflexive meta-position].

"What questions have you not asked so far?"

5th Phase:

Evaluation:

Up to this phase of interview, the cognitive profile and cognitive mechanisms have been illuminated. The following phase brings together the cognitive profile, cognitive mechanisms, and in link, experiencing-self; and further explicates the relationship between each category with the aim to trigger further reflection with again a prompt to develop a meta reflexive perspective and prompts further reflection as therapist moves towards meeting with client group in the spirit of dialogue and Gadamerian hermeneutics:

1. "When you now move through your thoughts, ideas and reflections are there any changes or maybe surprises?"
2. "As we stepped through your thoughts and reflections has this influenced how you see or understand you're self?"
3. "Or has it influenced the way you may observe or relate to the client group at your next meeting?"
4. "When we put our thoughts and observations together ….has this process altered the way you may sit with the client group?"

2nd Position Statement Evaluation:

Request participant to look at *initial position* and consider would they revise their position.

> "If we take a step back and think about what we have been reflecting over,
> how can we now describe our thoughts in relation to the stuck experience
> and the client group that you introduced?"

Draft 7: Post consultation 5

This draft is for use in Consultation 6:

Consultation 6:

The opening question of the interview entails an introduction to the Dialogical lens and the Consultation Model:

The aim of the opening question is to stimulate reflexive thought about therapist stuckness with research participants. The opening reflexive questions will be guided by the *phenomenology* mode of inquiry.

The interview then moves into the Consultation Model:

<u>Overarching Aim of Consultation Model:</u>

To externalise the internal dialogical activity of the therapist with the aim to explicate what the therapist brings to the therapeutic encounter [their historical ideas, reflections and experiences], how they experience the therapeutic encounter [i.e. they're here-and-now experiences as emergent in the therapeutic activity] and how they participate and respond to the therapeutic encounter so as to gain new insights into their unique-self, how they position themselves in the therapeutic activity, how they their observe the client group with a move towards a response building reflexive activity that brings together in an inclusive, welcoming environment all of their ideas and reflections with a direct interest and responsiveness towards all aspects of the family group, their narratives, insights and experiences [see Rogers, 1951, 41].

To achieve this aim the dialogical model in practice aims to prompt the therapist to move through a number of reflexive activities:

1. To move towards the development of a non-hierarchal cluster of dialogical voices or in systemic terms, the articulation of all ideas, reflections and hunches with the task to develop an open, multi-positioned self-dialogue.
2. To move the therapist towards an enhanced insight into how they position themselves in relation to the identified client group through the exploration of the internal dialogue with emphasis on their experiencing reflections.
3. To move towards the development of a meta-observational position, as developed through the externalising of the community of internal voices, which enables the therapist to view all voices or in systemic terms , all ideas, reflections and self-experiences and their relationships in a more transparent environment, with the aim to work towards a community of linked voices, or in systemic terms, linked ideas,

thoughts and observations that will create a multiplicity of thought and a flexible perspective to family or client group stories and dynamics.

4. To support the therapist to move into a *reflexive trajectory* that encompasses and articulates an interest in the family experiences, historical stories and emergent narratives and how they translate to the therapeutic encounter and how they *connect* with therapist's reflections and observations [empathic reflections];
5. To support the therapist to move into an inclusive response building reflexive activity that appreciates and welcomes all ideas, both client group and therapist, sees all as worthy with a Gadamerian movement between all observations, reflections and ideas [see Rober et al, 2008a].

Interview and Consultation Model:

Pre-Consultative Model exploratory dialogue:

Task:

To understand how the therapist experiences a stuck phase in therapy.

Researcher to introduce the dialogical approach to a stuck episode and request participant to partake in consultation influenced by dialogical theories.

Pre Consultation Tasks:

1. The Dialogical Model to be introduced to participating therapist: Hermans [2008] ideas of dialogical positions to be aligned with characters in a play entering the stage at different points.
2. To explain to participants the meaning of the professional self, the systemic-self, and the experiencing-self. This discussion will assist the participants to understand the model questions and respond to model questions in a manner that facilitates their own reflection in relation to the stuck encounter.
3. Inform participants that notes will be taken with focused reference towards mapping the *Position Statements*: this task is to enable the participant to view and track the statements, to track changes of perspective, and to aid the development of a meta-observational reflexive position in relation to the stuck encounter.

Opening question:

Aim: To understand how the therapist experiences a stuck phase in therapy. The question is moulded by the phenomenological perspective. The aim is to prompt a description that brings into focus the experiencing self-narratives of the therapist.
Opening Dialogue:

"How do you experience a phase in therapy when you are stuck?"

To move into the Consultative Model as framed by the dialogical perspective:

The Dialogical Consultative Model:

1st Phase:

Aim: To commence understanding *how the therapist experiences* [selected highlight] the stuck phase:

Opening Dialogue: Researcher requests participant to describe the stuck phase that they are encountering:

1. "Let us look at the therapy process...when you sit with the client group that you have identified what do you observe?"
2. "What is it like to sit with this family and hear their stories?"

Progress dialogue into understanding the dialogical movement towards the stuck phase. This opening phase aims to prompt the therapist to describe how they understand a stuck phase:

3. "We opened the interview with a look at how we can understand stuckness …with this family how did you notice that you were moving into a stuck situation?"

Prompt: How was this experience different from a period in therapy that you felt there was movement?

2nd Phase:

The Position Statement: The Initial Evaluation: The task is to establish an *initial position* towards the stuck phase: The participant is requested to formulate a specific personal sentence or reflections that will refer to their *initial position*. This statement aims to support the therapist to move towards a meta-observational position:

"How can you now describe how you understand or observe the stuck phase?"

3rd Phase:

Aim: To begin externalising the internal dialogical process of the therapist as they are *experiencing the stuck phase*:

Opening dialogue. Consultant requests participant to identify the theoretical, systemic and experiencing positions from which they frame the stuck experience.

Questions that assist in eliciting internal dialogue:

Professional and systemic domain [potential to elicit pre-assumptions]:

When you began to observe that you moved into a stuck phase what...

4. "What professional ideas or questions arose?"[85]
5. "What systemic ideas or questions arose?"
6. "Are you conscious of another professional or systemic idea in the background?"[86] Prompt: "Where do these ideas come from? Potential to elicit patterns of practice, bias and preferences.
7. Or are you conscious of other ideas or observations?[87]

Experiencing domain:

The explication of this domain encourages the therapist to observe their experiences and by doing so encourages an observation of the client group's experiences and stories and how they translate to the therapist's experiences [*empathic reflections*]:

When you began to observe that you moved into a stuck phase what...

1. "What hunches did/or do you experience?" Prompt: "With the hunches, did you experience any feelings or emotions?"
2. "Tell me a little bit about these hunches? Prompts: Briefly describe the story behind each voice; what are these hunches, feelings, emotions telling you to look at or do?"

[85] This lens is important as it may dictate therapeutic process, added at consultation 6.
[86] This question was added in format 4, see action research notes.
[87] Potential to prompt moral compass or other subliminal voices, added at Consultation 6.

3. “With these hunches, are they showing you something different about the family. Prompt: Are they highlighting an aspect of the family group or story? What questions did you pose to yourself?”

Potential to further elicit self-experiencing positions and potential to elicit reasoning or negotiating strategies between professional/ systemic and experiencing-positions.

4. “Are you conscious of a hunch in the background or emerging in the background?” May prompt moral compass or other subliminal voices.

4th Phase:

Aim: Enactment of internal dialogues as drawn from the ideas of the dialogical–self theories and the ideas of Rober [1999; 2008a; 2008b, 2008c] and Rober et al [2008a, 2008b] and William Stiles [meaning bridges concept and sub communities concept as developed in the Assimilation model and correlated research projects]. Participant requested to further explicate the relationship/tension between voices as evoked by therapeutic encounter i.e. to look at stuck phase through alternative frames or alternative internal positions and compare. This phase will aim to prompt the move towards a meta-observational reflexive position and draw attention towards the therapists observation of their–self and the client group, the stories they bring to the therapeutic encounter and how that fits with the therapists reflections and ideas of how to move forward:

Let us bring together the ideas, reflections and hunches that you have spoken of:

5. “What is your professional or systemic-self saying about the stuck phase?”
6. “What are your hunches saying to you about the stuck phase?” Prompts: What are your hunches or experiencing self-telling you to look at?”; “What are your hunches or experiences telling you to do?”
7. “Are these feelings, hunches and ideas familiar?”
8. “Or are any of the ideas, feelings or hunches unfamiliar?” Prompts: “Did any of your hunches surprise you?”; “Did any of your hunches perturb you?”
9. “Does any of these ideas, reflections or hunches prompt or evoke other ideas or experiences that you had forgotten about”
10. “How are your systemic ideas fitting with your hunches?” [Meaning bridge process]
11. “Is this client group evoking positions that you do not normally utilise?” [With the aim to elicit the potential for the influence of particular family stories, presentations, idiosyncratic positions or positions as manifested by the family that may evoke

therapist prejudices: this process reflective of Gadamerian ideas in relation to prejudices aims to support the therapist to be more aware of their position and how it influences their observational lens etc.]

12. "If so, is this process uncomfortable, or is it comfortable?"
13. "What questions do you think you could ask?" [To move dialogical process towards a reflexive meta-position].
14. "What questions have you not asked so far?"

5th Phase:

Response building phase:

The following phase brings together the cognitive profile and in link, experiencing-self and further explicates the relationship between each category with the aim to trigger further reflection with again a prompt to develop a meta reflexive perspective and prompts further reflection as therapist moves towards meeting with client group in the spirit of dialogue and Gadamerian hermeneutics:

1. "When you now move through your thoughts, ideas and reflections are there any changes or maybe surprises?"
2. "As we stepped through your thoughts and reflections has this influenced how you observe you're self?"
3. "Or has it influenced the way you may observe or relate to the client group at your next meeting?"
4. "When we put our thoughts and observations together ….has this process altered the way you may sit with the client group?"

2nd Position Statement Evaluation:

Request participant to look at *initial position* and consider would they revise their position.

> "If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation to the stuck experience and the client group that you introduced?"

Post Consultation/client group review discussion:

1st Phase:

Aim: To trace how therapist transfers evolving reflexive/ dialogical activity in response to Dialogical Consultation to therapist /client dialogue:

"How did you experience meeting with the identified client group after the consultation?"[88]

2nd Phase:

Aim: To evaluate if the processing of therapist stuckness as influenced by the dialogical perspective was of therapeutic value to the therapeutic process [Questions are more focused]:

1. "On reflection, did the consultation alter the way you observed the stuck phase?"
2. "Did the consultation alter the way you observed yourself in relation to this family system or client group?"
3. "Did this process alter the dialogue or did you observe a change in the themes you introduced or called attention too"
4. "Did this process assist in resolving the stuck encounter?"

3rd Phase:

The Position Statement: Request participant to look at *initial position, position statements,* and consider would they revise their position:

> "If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation to the stuck experience that you introduced?"

Closing discussion: Post Dialogical Model:

Aim: Over view evaluation:

Suggested Question [In the spirit of Gadamerian Hermeneutics, phenomenology and the dialogical perspectives!]:

"What are your thoughts on the dialogical model?"

[88]Question 2 has been deleted in that it is repetitive and too lengthy: [2] "Describe the dialogue between yourself and the client group".

Appendix 9:

The Dialogical Consultation Model in Practice:

[Draft 8: Modified Draft Post Consultation 6: The concluding draft of model]:

The model format will follow with each reflexive phase introduced with an overview of its aim:

Phase One: Introduction to Dialogical Consultation Model:

The aim of phase one is to introduce the Dialogical Consultation to the participating family therapist. The following features of the model are to be introduced at this stage in order for the consultation to be useful:

1. The consultant is to introduce the Dialogical Model to participating family therapist: Hermans [2006] stage play concept to be included at this stage.
2. The consultant is to explain to participants the meaning of the professional-self, the systemic-self, and the experiencing-self. This discussion will assist the participants to understand and respond to the model questions in a manner that facilitates their own reflection in relation to the stuck encounter.
3. Inform participants that notes will be taken with focused reference towards mapping the "Position Statements" [see Cunha, 2007, 302]: The Position Statement concept entails the therapist formulating a specific personal sentence or reflections that will refer to their position towards the stuck phase. This statement aims to support the therapist to move towards a meta-observational position. Over the course of the consultation, the therapist will be requested to formulate two Position Statements. The first Position Statement [the initial statement] will be requested at phase two of the dialogical model. The second Position Statement will be requested at the end of the consultation. Each statement will be recorded on a card and maintained in sight for reflexive purposes. The Position Statement is an important feature of the model. To the participating therapist it supports the development of a meta–observational reflexive position [see Rober et al, 2008a, 2008b] from where they can observe how they reflect on the stuck experience. And, as the consultation progresses, it offers the participating therapist an opportunity to track any changes in how they observe the therapeutic encounter and how they observe themselves and their engagement with the client group with the aim to support different ways of connecting with the client group and the stories shared.

The task of the first Position Statement is to establish an initial perspective towards the stuck phase and support the therapist to move towards a meta-observational perspective [see Stiles et al, 2004; Rober et al, 2008a].

Initial Position Statement question:

"How can you now describe how you observe the stuck phase?"

The task of the second position statement is to support the therapist to observe their position towards the stuck experience at the conclusion of the consultation, to compare with initial position, track any emergent changes with the aim to support alternative perspectives and ideas, and ways to connect with client group.

Closing Position Statement questions:

"If we take a step back and think about what we have been reflecting over, how can we now describe our reflections in relation to the stuck experience that you introduced?"

Phase Two: Commencement of Dialogical Consultation:

Aim: To understand how the therapist experiences a stuck phase in therapy. The question is moulded by the phenomenological perspective. The opening question aims to prompt a description that brings into focus the self-narratives of the therapist:

Qu. 1: "How do you experience a phase in therapy when you are stuck?"

Phase Three:

Aim: To commence understanding how the therapist firstly, describes the therapeutic encounter and secondly how the therapist experiences the identified stuck phase:

Tasks:

The participating family therapist is requested to firstly describe the therapeutic trajectory from the family's perspective;

Secound, the therapist is requested to describe the therapeutic encounter from their perspective.

The therapist is then requested to describe the stuck phase that they are encountering.

The questions are framed by the phenomenological, dialogical and Gadamerian hermeneutic lens with the aim to shift the description of the client group, what they bring to the

therapeutic encounter, and how the therapists observes the encounter, from a clinical or objective description to a description that incorporates the multiple reflections, to include the voice of the therapist, the voice of the client group, the therapists experiencing-self ideas and how they connect:

Qu. 2: "Describe how the family observe and/or share their story"[89]

Qu. 3: "Describe your journey with this family"

Qu. 4: "Let us look at the therapeutic process...when you sit with this family what do you observe?" Prompt: "What images do you have in your mind when you hear the family's stories?" [See Rober, 1999][90].

Qu. 5: "What is it like to sit with this family and hear their stories?"

Consultation moves into the initial Position Statement:

The Position Statement: The Initial Evaluation:

Task: To establish an initial position towards the stuck phase:

Qu.: "How can you now describe how you observe the stuck phase?"

Phase Four:

Aim: To progress dialogue into understanding the dialogical movement towards the stuck phase.

Qu. 6: "We opened the interview with a look at how we can understand stuckness …with this family how did you notice that you were moving into a stuck situation?"

Prompt: "How was this experience different from a period in therapy that you felt there was movement?"

Phase Five:

Aim: To commence externalising the internal dialogical process of the therapist as they are experiencing the stuck phase:

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[89] This question was added post consultation 6 with aim to promote the internalized-other voice, and in response, promote the intersubjective space, and in systemic term, to support a more personal connection with the family.

[90] This prompt was added post consultation 6 with the aim to evoke a reflection on the family's story in a manner that gives it depth and generates a curiosity about what has been said and not yet been shared.

Opening dialogue. The family therapist is requested to identify the professional parameters, the systemic ideas and self-experiencing reflections from which they frame the stuck experience.

Questions that assist in eliciting the therapist's internal dialogue:

Professional and Systemic Domain [potential to elicit pre-assumptions]:

When you began to observe that you moved into a stuck phase:

Qu. 7: "What professional ideas or questions arose[91]?"

Qu. 8: "What systemic ideas or questions arose?"

The following questions explore the presence of a sub-community of ideas and reflections that together can dominate the therapeutic lens and if articulated can diminish their influence:

Qu. 9: "Have you noticed other ideas emerging that don't necessarily fit with the professional or systemic ideas?"[92]

Qu.10: "Are you conscious of another professional or systemic idea in the background?"

The Self- Experiencing Domain:

Aim: This section has the potential to elicit the emergent self-experiencing reflections and their historical component as prompted by the therapeutic encounter. This reflexive activity encourages an observation of the client group and the stories they share and how they translate to the therapist's experiences with the potential to generate empathic reflections [see Stiles et al, 2004; Brinegar, Salvi, Stiles, and Greenberg, 2006]:

Domain 1: To support therapist to observe their self–experiences[93]:

When you began to notice that you moved into a stuck phase:

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[91] As the consultations of this project advanced, it came to light that the professional lens is significant in practice. It has the potential to dictate the therapeutic activity. This question was added at consultation 6.

[92] This question has the potential to prompt reflections or ideas that arise from the moral/ethical lens or other subliminal reflections. This question was added at consultation 6 following the emergence of ethical reflections attached to historical self-experiencing reflections in all research consultations.

[93]This section has the potential to elicit self-experiencing reflections and their historical component.

Qu. 11: “Did you experience or notice any hunches emerging?”

Qu. 12: “If so, tell me a little bit about these hunches?
Prompts: “Briefly describe the story behind each hunch or reflection”; “Do the hunches remind you of any of your own personal stories?”; “ Or, do the hunches bring forward any of your own personal stories”; “What are these hunches, feelings or emotions telling you to look at in terms of the client group or the therapeutic process?”

Domain 2:
Aim of domain 2:

1. This line of inquiry, in correlation with question 8 and 9, has the potential to further elicit the self-experiencing reflections and how they are positioned within the multiple of reflections.
2. This line of inquiry will have the potential to support the therapist to reflect on the client group, the stories they share and how they connect with their own self-reflections and how they position these stories in the therapeutic process [The internalised-other].
3. This line of inquiry has the potential to elicit the reasoning or negotiating strategies between the professional, systemic and the self- experiencing positions. This reflexive process has the potential to support the therapist to observe the incidence of dominance/submissive reflexive trajectories i.e. the silencing of certain reflections and ideas or the formation of sub-communities of reflections or ideas, or alliances, with the aim to support the therapist to move towards a community rather than sub communities of ideas and reflections [see Stiles et al, 1990; Brinegar et al, 2006]:

Qu. 13: “With these hunches, are they showing you something new or different about the family?”
Qu. 14: “Are they highlighting a different aspect of the family group or story that you have not to date explored?”

Qu. 15: “Are these feelings, hunches or ideas familiar?”

Qu. 16: “Or are any of the ideas, feelings or hunches unfamiliar?”
Prompts: “Did any of your hunches surprise you?”; “Did any of your hunches perturb you?”

Qu. 17: "Do any of these ideas, reflections or hunches prompt or evoke other ideas or experiences that you had forgotten about"

Qu. 18: "Is this client group evoking positions that you do not normally utilise?"

Aim: To elicit the potential for the influence of particular family stories, presentations, idiosyncratic positions or positions as manifested by the family that may evoke therapist prejudices. This process reflective of Gadamerian ideas in relation to prejudices aims to support the therapist to be more aware of their position, how it influences their observational lens, and how it may support new ways of observing client group [see Gadamer, 1976, 1990/1960].

Qu. 19: "If so, is this process comfortable, or is it uncomfortable?"[94]

In addition to above cited aims, the following questions aim to move the dialogical process towards a reflexive meta-observational position:

Qu. 20: "What questions do you think you could ask?"

Qu. 21:"What questions have you not asked so far?"

Phase Six:

Aim: This line of inquiry aims to prompt an enactment of the internal dialogues as drawn from the ideas of the dialogical–self theories[95]. The family therapist is requested to further explicate the internal dialogical process and to explicate the relationship/tension between ideas and reflections as evoked by therapeutic encounter i.e. to look at stuck phase through alternative frames or alternative internal positions with attention towards the client group, the stories they bring to the therapeutic encounter and how that fits with the therapists reflections and ideas of how to move forward:

From that line of inquiry, this phase will aim to further support the therapist to move towards an observational reflexive position that encompasses all reflections, both the therapist and client group, in an inclusive mode:

[94] These questions may have the potential to elicit the moral/ethical lens or other subliminal reflections that have a predisposition to attach to the experiencing-self reflections.

[95] See Hermans [2001b]; Rober [1999; 2008a; 2008b, 2008c]; Rober et al [2008a, 2008b]; Stiles [1990]; and Stiles et al [2004].

Let us bring together the ideas, reflections and hunches that you have shared[96]:

Qu. 22: "What is your professional or systemic-self saying about the stuck phase?"

Qu. 23: "What are your hunches saying to you about the stuck phase?"

Prompts: "What are your hunches or experiencing self telling you to look at?"; "What are your hunches or experiences telling you to do?"

Qu. 24: "How are your systemic ideas fitting with your hunches?"

Qu. 25: "How are the professional parameters fitting with the systemic ideas and your hunches?"

Phase 7:

Response Building Phase [see Rober, 1999; Rober et al, 2008a, 2008b; Stiles et al, 2004]:

Aim: Up to this phase of the consultation the professional, systemic, and experiencing reflections of the therapist; and the reflections and insights of the client group [as observed through the therapist observational and reflexive lens] have been illuminated. The following phase brings together all reflections and further explicates the relationship between each category. The aim is to support the therapist to develop an inclusive observational reflexive perspective that prompts further reflection as the therapist moves towards meeting with client group in the spirit of dialogue and Gadamerian hermeneutics:

Qu. 26: "When you now move through your thoughts, ideas and reflections are there any changes?"

Qu. 27: "As we stepped through your thoughts and reflections has this influenced how you observe you're self?"

Qu. 28: "Or has it influenced the way you may connect with the client group?"[97]

Qu. 29: "Do you think there may be questions, ideas or themes that you could bring into the next family meeting?"

Prompt:

"Or, are there questions that have you not asked so far?"

"Or, what is yet to be known of this family and the stories they share".

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[96] See Brinegar, et al, 2006; Stiles, et al, 1999; Stiles et al, 2004.

[97] Post consultation 6 question 25 and 26 were combined.

Qu. 30: “Is this dialogue dissolving any of the concerns that you introduced to this consultation?”

Consultation completes with the second Position Statement:

2nd Position Statement: Evaluation:

Request participant to look at initial position and consider would they revise their position:

“If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation to the stuck experience that you introduced?”

To conclude:

“If we take a step back and think about what we have been reflecting over, how can we now describe our thoughts in relation how to connect with the client group whose story you introduced today?

Appendix 10: A therapist reflexive tool for use in systemic practice:

Reflexive platforms:	*Reflexive question:*	*Aim of question:*
Platform 1:	"Share with me this family's story..."	To support a reflection of the dialogical other and to ensure that the family's story becomes central to the reflexive activity. This activity in addition promotes therapists observation of self within the family's description and from that position the potential development of empathic observations and responses that are meaningful to the encounter.
Platform 2:	"Let us be curious about the wider picture of the family, their journey and the stories they share..."	As above.
Platform 3:	"Describe how this family observe or share their story..."	Again, this question aims to support a reflection on the family's perspective and what aspects of their story are meaningful to them.
Platform 4:	"Describe how you observe this family's journey..."	This question shifts the reflections towards the therapist's unique-self. It will have the potential to prompt three connected reflexive positions: a reflection on the family and how the therapist has internalised them, a reflection on the therapist's experiencing-self, and, from these positions, a reflection and potential development of empathic observations and responses.
Platform 5:	"Describe your journey with this family..."	Similar to platform 4, this question promotes a wider description of the encounter, with an emphasis on the therapist's experiencing-self and how it connects with the family story with the potential to generate empathic observations, reflections and responses.
Platform 6:	"When we wonder about this family can we find clues that would take us somewhere new...?"	This question promotes the horizon concept as described by Gadamer [1990/1960]. A question influenced by the horizon concept supports the reflexive activity to value the old ways of engaging, hold on to its knowledge, and not necessarily depart from this position but to look over the horizon and search for other ways of exploring that moves forward but also holds on to the past in a constructive way.

Appendix 11:

Research reflexive framework as guided by Gadamerian Hermeneutics: [1990/1960][98] :

Domains:	*Reflexive Domain:*	*Reflexive Questions:*
Domain One:	Researcher Self-Reflexive Dialogue: Researcher's horizons of understanding [see Gadamer, 1990/1960].	<u>Pre research activity:</u> "What research questions do I pose?" "Why am I interested in this theme?" Prompt: "What is the story behind my project?"[99] "What do I bring to this inquiry?" "Am I, as the researcher, open to my existing understanding of the research theme and suggested approach? "Prompt: "in what way does my initial understanding of the research theme influence my observational lens?" "How do my ideas /impressions of the research theme influence the way I observe the research theme?" "Am I, as the researcher, open to alternative ways of observing the research themes?" prompt: "Have I observed alternative ways of understanding the phenomena under study?" <u>Research Process:</u> "Am I open to what I may observe during the course of the research?" "Am I engaging in any emergent shifts in understanding?" "Am I open to accommodating the research participants understanding?" "How do the research participant's ideas or reflections influence my observation/understanding of the research theme?" "Am I open to modifying my observation/understanding in response to the participant's observations?" "How does my initial understanding fit with my evolving understanding?" "What can I add to this inquiry? "Prompt: "Do my ideas/reflections support a new, richer, alternative or contradictory way of observing the research theme?" "What do I hope to bring from the inquiry?"
Domain Two:	Reflection on meaning making trajectory of research participant:	<u>Pre research activity:</u> "What are my expectations of the participants and their role in the project?" "What do the participants' bring to the inquiry?"

[98] Amended draft post research.
[99] Prejudices provide the *opportunity* to start the process of observation.

	Participants horizon of understanding:	"What is their existing understanding of the research theme?" "How does their existing understanding fit with my initial reflections?" <u>Research process:</u> "How do they observe the research theme? "Prompt: "What reflections or ideas do they introduce into the research dialogue?" "How do they engage with the research theme?" "How does the input, ideas or reflections of the participants influence the research dialogue?" "How have I brought to the fore all the ideas or reflections of the participants? " "What do they bring from the inquiry?"
Domain Three:	Intersubjective Reflection: Reciprocal interpretation:	"Are both parties offered the opportunity to reflect on the horizon parameter or bias perspective of the other?" "Are both parties open to reflecting on the horizon parameter or bias perspective of the other?" "Negotiating process: Are both parties offered the opportunity to move into a frame of mutual reflection?" "Does the interview process provide a dialogical space for the introduction and mutual exploration of the research theme, or different, new or conflicting ideas or reflections?" "Does the interview process support a "not knowing" position [Gadamer, 1990/1960, 383]?" "Do the horizons of understanding shift or accommodate new meanings or co-constructed meanings?" Prompt: "Is a new co-created meaning developed?" "Is there evidence to suggest that both the participants and I, the researcher, have moved our understanding of the research theme from the original description that was available at the start of the project to a description that is richer in that it accommodates or is influenced by the dialogic dialogue?"
Domain Four:	Critical Self-Reflexivity [Researcher]	"What is my role, as the researcher, in the interview process?" "How do I express this role?" "Do I impact constructively and without prejudice on the research dialogue and emergent dialogues?" Prompt: "How do I demonstrate a position of openness?" "Am I open to a mutual exploration of the research theme?" "Am I open to new, alternative or contradictory emergent themes?" "Do I camouflage my vested interest?" "Do I manipulate the research dialogue?"

Appendix 12:

Ethics approval letter:

04 April 2013

Dear Mrs. Richardson

Re: The approval of your application to register your thesis "The Potential Therapeutic Value of Therapist Stuckness in Family Therapy".

Course Title: PD in Systemic Psychotherapy Course Code: M10

I am delighted to inform you that the registration of the above thesis was considered at the UEL Research Degrees Sub-Committee (RDSC) on the 27th March 2013 and was approved. This means you will be formally registered from January 2011.

Your registration period lasts for a maximum of 60 months and a minimum of 30 months inclusive of a write-up period of a maximum of 12 months. This timeframe is calculated based on your status as a part- time student.

For details of suspension, extensions, reductions to the registration period and write-up status please refer to your PGRD handbook.

Please do contact me if you have any queries regarding the above, and please keep this letter for your records.

Best regards,

Rebecca Bouckley