

## **What's on the therapist's mind?**

### **A grounded theory analysis of family therapist reflections during individual therapy sessions**

**Peter Rober**, K.U. Leuven, Belgium

**Robert Elliott**, University of Toledo, U.S.A.

**Ann Buysse**, Ghent University, Belgium

**Gerrit Loots**, Vrije Universiteit Brussel, Belgium

**Kim De Corte**, Ghent University, Belgium

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Several authors have researched the therapist's experiences in therapy. For instance, Hill & O'Grady (1985) studied the intentions of therapists. Llewelyn (1988) studied the therapist's view of helpful and unhelpful events in therapy. Melton, Nofzinger-Collins, Wynne & Susman (2005) mapped the affective inner experiences of therapists in training. Cooper (2005) explored therapists' experiences of meeting their clients at a level of 'relational depth'. The most comprehensive previous research on therapist within-session experiences to date is that of Orlinsky & Howard (1977), using the *Therapy Session Report*. Besides describing 11 dimensions of client experience of therapy sessions, they also described 11 dimensions of therapist experience, sketching a composite portrait of the process of psychotherapy from the subjective perspectives of clients and therapists. Interesting as it may be, the *Therapy Session Report* taps therapist's global impressions of sessions, rather than therapist's experiences of particular moments within sessions. Other researchers have used tape assisted recall procedures in an attempt to stay close to the therapist's experience and concentrate on specific aspects of the therapist's experiences in the session. Elliott & Shapiro (1988), for instance, used tape-assisted recall to identify significant change events within therapy sessions and to obtain information about clients' and therapists' moment-to-moment experiencing during these significant events.

Instead of studying therapist experiencing in general, several researchers have focused on the therapist's information processing during the session and on his/her forming of hypotheses about their clients. They characterize the therapist as some kind of scientist working in a hypothesis-testing manner (e.g. Selvini-Palazzoli, Boscolo, Cecchin & Prata, 1980; Martin,

1992; Caspar, 1997). In the family therapy field, the influential original Milan team, for instance, describe the mental activity of the therapist as cybernetic cycle: observation, formulation of a hypothesis and experimentation. They write: "The greatest mental effort occurs in the second phase; it is then that the mind must organize the observations it has gathered. ... It is obvious that the brilliance (or the lack of it) of any research pivots upon the formulation of the hypothesis." (Selvini-Palazzoli, e.a., 1980, p.5) Family therapists have often viewed the knowledge of the therapist as the central issue in the therapeutic process. Even the popular concept "not-knowing" (Anderson & Goolishian, 1992; Anderson, 1997) suggests that therapist knowledge should be the key concern in the discussion about therapist's self in the session. As Anderson (2005) writes: "Not-knowing refers to an idea and attitude about knowledge (i.e. reality, truth, expertise) and the intent and way in which we use it." (p.502)

Partly based on critical reflections on Harlene Anderson's concept of *not-knowing* (e.g. Paré, 2002; Kaye, 1999; Lerner, 2000; Guilfoyle, 2003; Flaskas, 2002; Rober, 2002; 2004), a dialogical perspective is emerging in the family therapy field (Seikkula & Olson, 2003; Rober, 2004, 2005). Within this view, inspired by Bakhtin's concept of the dialogical self as a polyphony of inner voices (Bakhtin, 1981, 1984; Morson & Emerson, 1990; Hermans, 2004), some family therapists have described the therapist's self as an inner dialogue (e.g. Anderson & Goolishian, 1988; Penn & Frankfurter, 1994; Andersen, 1995; Anderson, 1997; Rober, 1999; 2002; 2005). The therapist maintains an inner dialogue with him/herself, which is the starting point of his/her questions. This dialogue has been called the *therapist's inner conversation* (Rober, 2002; 2005).

For some time we have been reflecting on ways to empirically study the therapist's inner conversation. Then we came across the work of David Rennie who did a grounded theory

analysis (GTA) of the client's experiences of an hour of psychotherapy (Rennie, 1990; 1992; 1994). He used a tape assisted recall procedure to obtain the accounts of 16 clients of their moment-to-moment experiences during the session. The transcripts of these accounts were analysed in terms of the grounded theory method. The core category Rennie found was *client's reflexivity*. This category highlights clients' active self-reflection, dealing with their own experience in interaction with the therapist. Inspired by this study of the client's experiences of the therapy session, we wanted to do the same kind of study for the experience of the therapist. We recognized in Rennie's approach an opportunity for us to address the therapist's inner conversation empirically. It would allow us to stay close to the lived experience of the therapist, while valuing the researcher's clinical skills and experience to enrich the study's results. In addition, mapping the in-session thought processes of experienced therapists may be useful to training novice therapists.

While several authors have written about the process of the therapist's inner conversation as an example of a dialogical self (e.g. Penn & Frankfurter, 1994; Andersen, 1995; Anderson, 1997; Hermans, 2004), and about the not-knowing attitude of the therapist (e.g. Anderson, 1997), thus far little attention has been given to the content of the therapist's inner conversation. Here lies the focus of this present study. In order to empirically investigate the therapist's inner conversation in clinical practice, we studied role-played therapeutic sessions using a tape assisted recall procedure (Kagan, 1975; Elliott, 1986). Our basic research question was exploratory in nature and formulated as: "What is the content of the therapist's inner conversation during the therapeutic session?" We wanted to get a sense of what the therapist is thinking and feeling during the session, where his/her attention is focused, what his/her experience of therapy is, and so on. We wanted, if possible, to catalogue the different reflections

therapists have during the session, and we hoped that this would help us to gain some understanding of the therapist's inner conversation.

## METHOD

### *Participants*

We studied the reflections of family therapists during initial individual sessions with a standardized client who presented with personal, relational and family problems. The sessions were recorded on videotape in a video-room in the Faculty of Psychology and Educational Sciences at Ghent University. In this study twelve therapists participated. All were experienced therapists: psychologists or social workers with training in marital and family therapy, meeting the criteria set by the BVRGS (*Belgian Association of Marital and Family Therapy*). The average age of the therapists was 45 years old. Six of the twelve participating therapists were licensed family therapy trainers. The therapists volunteered to participate in this research, in response to research announcements by professional family therapy associations (BVRGS, Feelings & Context, Kern) on their websites, on their meetings and via their mailings. The client was a 22-year-old doctoral student who played the role of a client. She was given one of three scenarios for each client she had to play. The scenarios were randomly assigned to the therapists. All three scenarios featured a 19-year-old woman student at the university who had phoned for an appointment. She wanted therapy because of personal and family difficulties.

We chose to work with a role played client for ethical reasons: we wanted to protect real clients from any harm a research orientation might have on the therapeutic services they were receiving. The participating therapists had a clear understanding that they were doing a role play with a doctoral student playing a client. They also knew the session would be taped, transcribed,

analyzed and used in scientific publications. They filled in an informed consent form, in line with the University of Ghent's ethical requirements. In order to protect the confidentiality of the participating therapists they have been given pseudonyms (Mrs. Orange, Mr. Black, Mrs. White, etc.) right from the start of the research and throughout the whole research process. Only the first author knows the real names of the participating therapists.

### *Procedure*

The session lasted between 30 and 40 minutes and was video-recorded. After thirty minutes there was an auditory signal to the therapist that it was time to end the session. The therapist then took a few minutes to finish the session, make a new appointment and say goodbye. Then, the researcher took the therapist to the video playback room. The recording of the session was played back, as a way of stimulating the therapist's recollection of what he/she was experiencing during the session. Every 45 sec. the tape was stopped and the therapist was asked to type into a laptop computer all thoughts, feelings and experiences he or she recalled having had at that point in the session. It was made explicit to the therapists that they were not being asked to give retrospective reflections, but instead were to try to recall what they had experienced at that moment during the session. In that way, we could obtain descriptions of the therapist's experiences at particular moments during the session.

The videotapes of the session were transcribed by two Masters-students under supervision of the first author. The first author added the notes of tape assisted recall of the therapist to the transcription in a second column, so that the notes of the therapist were put next to the session-sequence to which they referred. The notes of the therapist's tape assisted recall were the "text" we used to analyze in this study.

### *Analysis*

Grounded theory analysis (GTA) was used to analyze the transcripts. GTA is a qualitative data analysis method, rather than a method for theory verification (McLeod, 2001), developed as a general method for generating theory that is grounded in data systematically gathered and analyzed (Strauss & Corbin, 1994). Rather than testing pre-existing theoretical suppositions or hypotheses, GTA is emergent: Its aim is to develop categories from the data, leading to generating theory grounded in the data. GTA is often considered a good method for an initial exploration of a new, under-theorized domain (Burck, 2005; McLeod, 2001; Charmaz, 1995, 2006). The transcripts were divided into meaning units, each containing one complete idea of the therapist. The meaning units were coded line-by-line by the first author, using Max Qda software. The original transcripts of the sessions were used as reference in case the analyst needed to look up something that did not make sense out of context. Descriptive categories were identified and then the constant comparison method was used, constantly comparing meaning units and categories for similarities and differences.

This method was used on randomly selected transcripts one by one until theoretical saturation was achieved (i.e., to the point where a new transcript did not generate new categories, or did not help to elaborate on existing categories.) This occurred after eight protocols. As a check of the saturation of the categories, we categorized an additional 9th transcript (Mrs. Purple). This new transcript did not generate any new categories, but it did give some additional information in the lower, most specific categories that might help to make further differentiations. For instance: the categorizing of Mrs. Purple's transcript added new emotions to the category of the therapists "burdening emotions" (3.1.1.2.3.), as subcategory of "self focused

emotions" (3.1.1.2.) namely "despair" and "annoyed". The same for the therapist's "caring" emotions (3.1.1.1.2.) as subcategory of "client focused emotions" (3.1.1.1.): Mrs. Purple mentions feeling "sympathy" for the client. This confirmed our idea that the categories are saturated for the general model (i.e., the first 4 levels of the category structure), but for the research of more specific questions (for instance about the range of therapist's emotions in the session) it would be best to add extra transcripts. This would be in line with Charmaz' view (2006) that in general exploratory studies with modest claims earlier saturation can be acceptable.

This constant comparison resulted in a list of categories and subcategories, organized in a hierarchical category structure, where lower order categories are properties or instances of higher order categories. The highest order categories are called the domains. These domains form a general formal framework for the phenomenon under study.

To enhance the credibility of our study and the acceptability of its results by our respective scientific communities we have chosen to add to our method widely-used elements of Consensual Qualitative Research (CQR) (Hill, Thompson & Nutt-Williams, 1997); these elements provided us with tools to address concerns about researcher bias and reliability of our results. As a check on the trustworthiness of the first author's analysis, an auditing process was used (Elliott, 2004; Hill, Thompson & Nutt-Williams, 1997). Three experienced researchers from three different universities (R.E., A.B. and G.L.) were external auditors who reviewed the analyses of the first author (P.R.) and provided feedback. P.R. is trained as a family therapist and has a narrative/dialogical theoretical orientation. At the time of the study he was doing his Phd on the therapist's inner conversation. R.E. has a humanistic-experiential theoretical orientation. His auditing was influenced by that orientation and by his research on client and therapist in-

session experiences, especially on therapist intentions. Also his suspicion about the artificial nature of the role-played sessions colored his perspective. A.B. is an experienced quantitative researcher working mainly around personal relationship issues such as conflict, empathy, attachment, support, power, and divorce. G.L. is an experienced family therapist, as well as a qualitative psychotherapy researcher.

When the first author finished his coding of the meaning units, he made a detailed report to the first auditor (R.E.) in which the category system was presented, all categories were described as well as the way all meaning units (in Dutch with English translations) were assigned to categories. The auditor carefully read the report and reviewed the overall category structure for coherence/consistency as well as elegance/nonredundancy. Then he read through all the meaning units in both Dutch and English to make sure (a) that they fit the category they are located in and (b) that they did not also belong somewhere else. Then the first author again used the auditor's feedback to modify the category system and the way the meaning units were assigned. Then he made a new report incorporating the comments and suggestions of the auditor. That report was sent to all three auditors (R.E., A.B. and G.L.). They again reviewed it independently, and gave feedback to the first author. Next a final report was made, again incorporating the feedback of the three auditors. This final report was then sent to the auditors for their final approval.

## **RESULTS**

### ***Categories and Domains***

In the Grounded Theory Analysis, saturation was achieved after analyzing the transcripts of eight therapists. The transcripts of the other four therapists were not used. The 8 transcripts

were divided in 906 meaning units, and a total of 1074 codes were assigned to these meaning units. The complete list of all 282 categories can be found in the Appendix. Four general domains of categories of reflections were distinguished, elaborated, and clarified in the course of the analysis:

1. **Attending to client process:** This refers to the therapist's focusing on, and trying to connect with the personal process of the client in the here-and-now of the session. The attention is on the client.
2. **Processing the client's story:** This refers to the therapist's processing the content of the client's story about there-and-then (the world outside the session).
3. **Focusing on the therapist's own experience:** This refers to the therapist as a living, experiencing human being (emotions, reflecting, self-talk, and so on) in the here-and-now of the session.
4. **Managing the therapeutic process:** This is the domain of the therapist's managing of the process from the perspective of his/her responsibility as a therapist: taking care of the therapeutic context, assisting the client in the telling of her story and reflecting on therapeutic interventions. The therapist is focused on what he/she can do in order to help the client.

One additional domain, Reflections on the Artificial Situation, was added late in the analysis, to address concerns about the use of a standard client role playing a scenario. A total of 12 reflections were categorized in this category.

### *General model*

In grounded theory, categories are often organized around a central explanatory concept called the *central category* or *core category* (Strauss & Corbin, 1998). The major categories are related to this central category, which captures the essence of the phenomenon under study. In our study, we did not find a suitable core category, probably because of the breadth and complexity of the topic of the inner conversation. Each of the domains seemed to be, if not a core category, then an essential aspect or constituent of the therapist's experience.

The four domains are connected with each other in many different ways. The *managing of the therapeutic process* (4) is linked as much with the *attending to the client's process* (1) as with *processing the client's story* (2), and with the *focusing on the therapist's experiencing* (3). This model is circular and cyclical. In the therapist's inner conversation every category of reflections can come first, but every category can also come last in the therapist's train of thought. The therapist's focusing on therapeutic action (domain 4), for instance, can be the first step of the process (leading to therapeutic action and consequently to a reaction of the client that can be observed), but it can also be the last step in a process that starts with listening and observing, through experiential integration, to reflections on what to do next.

### ***Examples of Key Themes Connecting Interrelated Categories***

In this article we wanted to offer a concise general outline of this GTA study. Because of obvious limitations of space, we cannot focus in any detail on anything but a sample of the interesting findings of this study. Further publications will focus on different aspects of our findings, and discuss the implications of these findings for our understanding of the self as therapist in the therapeutic process (cf. Rennie, 1990, 1992, 1994). In this article, however, in order to illustrate the results, we have chosen to put the spotlight on one general process, that of

therapists trying to be *in tune with their clients*. This general process seemed to have three subthemes: First, scanning the taxonomy of the therapist's reflections (see Appendix), it becomes clear that throughout the session the therapist worked on having a *good working relationship* with the client. Thus, the therapists wanted in general to be in contact with the client's personal process (domain 1) and, in particular, they tried to understand the client's expectations (1.2.).

Second, therapists evaluated their own therapeutic actions by continuously monitoring and evaluating the client's reactions to them (1.1.2). More specifically, we noticed that the therapists put a lot of energy into the creation of a room for the client to talk (4.1.). They did this in constant dialogue with the client. It seems as if the therapist tried to create a safe therapeutic space (4.1.1.) in the conversation in which the client can talk or express herself. One therapist used the word "room to play" to refer to this space (Mr. Blue 14.30). Another therapist talked about "conversational space" (Mr. Black 31.45). Yet other therapists used the words "space to talk" (Mrs. Orange 02.15), or "forum" (Mrs. Orange 07.15). All used spatial metaphors. They seemed to refer to a *shared intersubjective space* in which certain processes like story telling (4.4.), information gathering (4.2.4.) or exploration (4.2.2.) could take place.

Third, it was important to the therapists to use the *client's voice as a guide* to help them in managing the therapeutic space (4.1.1.). In all 8 transcripts the therapist was concerned with tuning in to the client's expectations, preferences and sensitivities as much as possible. The therapist tried to understand the client's expectations (1.2.) and they monitored and evaluated the client's reaction to them (1.1.2.). Even in their choice of words, the therapist was in dialogue with the client as they tried to find out what words would be acceptable for clients to use in the conversation (4.4.2.). For instance:

(Mrs. Orange, 18.15) “Can she accept that I say something positive about her? Is calling her ‘responsible’ too strong/sharp? ...No, it is allowed.”

The precise wording of her statement to the client seems to be very important to this therapist. This was typical also for how other therapists chose what words to use in the conversation with the client. Indeed, the therapists were concerned that the words they used would be accepted by the client. They tried to use words that their clients would agree with. They wanted to picture things in a way that would be acceptable for their clients. They wanted to phrase their thoughts in such a way that their clients could go along with the way they described things. In the example above, Mrs. Orange tried to see if the client would accept the word “responsible”, and monitored the client’s reaction to see if she would reject the wording as being too sharp or too strong. She seemed relieved to find that the client accepted the wording (“it is allowed”). In six of the eight transcripts in this study, this kind of reflection could be found of therapists dealing in a dialogical way with their choice of words in the conversation with the client, suggesting that this kind of reflection is a typical example of the dialogical nature of therapists within-session reflections.

### ***Informant Validity Check***

As a further check on the trustworthiness and credibility of our findings we also talked about our findings with the participating therapists in a feedback session, one year after the sessions were taped. All 12 therapists were invited to come to Ghent University again for this feedback session. Nine therapists attended the meeting. In the meeting we first talked about our findings: we presented our general model with the four domains, and the main categories of therapist reflections. Then we asked them for their comments: Does this fit with your experiences as

therapist? What does fit? What does not? The therapists were invited to reflect on these questions among each other, without the researcher present. There was an animated discussion between the therapists. After approximately 45 minutes the researcher invited them to share their thoughts and comments on the findings. In general, the therapists found that our findings fit their experiences. In the discussion, they focused especially on the issue of complexity/simplicity. They found that our view of the therapist's inner conversation is more complex than most models of the therapist's self that so nicely fit a medical model: "questioning the patient, formulating an 'objective' diagnosis, and then administering a treatment". In a medical model it is as if the therapist is not present as a person in the session. The participating therapists appreciated that our model of the therapist's inner conversation is not just about therapeutic strategies and interventions. What therapists experience in sessions (e.g. mundane thoughts, feelings, ethical/aesthetic appreciation) is validated in the model, they said. Also, they appreciated that our model is a cyclical, circular model. According to them it seemed a model that would be very useful in training and supervision, as it opens space to talk about the complexity of the therapist's experiencing during the session.

On the other hand, the participating therapists also warned that even this rather complex view of the therapist's inner conversation might be too simple and too general to really represent the therapist's experiencing. They remarked that in reality the experiencing of the therapist is even more complex than the findings of our study suggest. For instance, they reported that there were reflections they had during the session with the client that they had not mentioned in the tape assisted recall procedure, because at that time these reflections did not seem relevant (e.g. thoughts about their personal life that did not seem to have anything to do with the session or with the research). Also, they pointed out that this research is about a first session, and that the

therapist's reflections might be different in later sessions. The therapist might focus even more on the process of the client, and be less concerned about gathering information and formulating hypotheses.

## DISCUSSION

### *Trustworthiness and validity*

Validity in qualitative research is not a question of correspondence with some objective external reality. It is more a question of defensible claims (Kvale, 1996): are the claims we make faithful to the data? In such a view validation can be seen as the rigor and the quality of the craftsmanship of the research (Kvale, 1996). In such a view also the communication about the research is an aspect of validity: does the report of the research give the readers the opportunity to judge the trustworthiness of the research and the credibility of the findings? In the end it is up to the readers to evaluate the validity of a research. It is up to the consumers of the research to decide if anything that is offered has any usefulness for them. For this reason we have tried to present a clear account of the design and the methods used to gather information, transcribe and analyze the data in this report.

Notwithstanding our view of validity as quality of craftsmanship, we used two additional procedures to check the validity of our research findings. Firstly, as we noted earlier, we checked the validity of the first author's analyzing work through a consensus process with three external auditors (Elliott, 2004; Hill, Thompson & Nutt-Williams, 1997); in addition, we also assessed informant validity via a feedback session with nine of the twelve therapists. Thus, as recommended by Elliott et al. (1999), the analysis was subjected to multiple validity checks.

The therapist feedback session was particularly valuable to identifying the strengths and limitations of the data and the analysis.

### *Saturation of the categories*

It could be argued that the eight main transcripts used in the analysis were not sufficient to fully map the phenomenon of therapy in-session experience. In GTA, however, researchers analyze until their categories are saturated, and this logic supercedes sample size (Glaser, 1992). But what is the best way to define saturation? Strauss & Corbin (1998) write: “a category is considered saturated when no new information seems to emerge during coding.” (p.136) They add that this is a matter of degree: “There is always the potential for the ‘new’ to emerge. Saturation is more a matter of reaching the point in the research where (...) the ‘new’ that is uncovered does not add that much more to the explanation at this time.”(p.136) The words “at this time” are interesting here, as they seem to stress that saturation is always provisional. Charmaz (2006) agrees with Corbin & Strauss that saturation is not a matter of absolutes. She writes that it is also a matter of credibility of the study: in a small exploratory study saturation might be proclaimed earlier than in a research in which hefty claims are made. So, in light of the modest claims we make in this present, preliminary study, when we state that the categories are saturated, we mean that the analysis of the last transcript did not add new categories, new properties of the categories or new theoretical insight to our general model, represented by the three- or four-level category systems in the Appendix. It should be clear, however, that further research on these data is still possible, and indeed even indicated, as it will undoubtedly enrich our general model.

### ***The richness and diversity of therapist reflections***

As noted earlier, we found 282 different kinds of therapist reflections in the 8 sessions, which illustrates the enormous diversity of a therapist's reflections during the session. While some models of the therapist's reflections focus on the therapist's cognitive mechanisms of information processing (e.g. Palazzoli-Selvini, Boscolo, Cecchin & Prata, 1980; Martin, 1992), stressing the importance of information, theories, knowledge, hypotheses and goals, our data offer a more fine-grained perspective on the therapist's experience of the therapy session. Our data draw attention to the very broad range of the therapist's reflections. Indeed, as most traditional models propose, our data show that the therapist gathers information, constructs hypotheses, and tries to formulate therapeutic goals. But our data also indicate that the therapist also doubts, hesitates, senses what the client experiences, notices the client's resources, is surprised, and so on. They show that therapists are emotionally affected by their encounter with the client, as they experience joy, relief, tension, dismay and so on. This paints a picture of therapists being present in the session as complete human beings in relation with their client, not just as an information processing/hypothesis testing mechanisms.

### ***Limitations of this research***

The data produced by the study are extraordinarily rich and complex. The analysis we report here is very general and merely scratches the surface: it describes in broad strokes the therapist's inner conversation as it is reflected in the data. More research is also needed to focus on specific aspects of the therapist's inner conversation we have only briefly touched upon here. For instance, given that therapists work hard to establish, together with the client, a safe room to talk and a respectful therapeutic alliance, how do therapists deal with threats or ruptures to the

“room to talk”, or to the therapeutic alliance? Furthermore, as it seems that therapists are willing to accommodate the client by working in terms that are more meaningful to him or her, the question can be posed what are the limits of this accommodating to the client's preferences? For instance, how do therapists remain authentic and real in the context of this process of accommodation?

More research is also needed to examine closely some of the topics we discussed in previous publications from a clinical perspective (Rober, 1999, 2002, 2004, 2005). In particular, since we have attached so much importance to the reflecting aspect of not-knowing in previous publications, it is important to try to articulate as accurately as possible what this process of reflecting is exactly, when therapists reflect and how they accomplish it.

This research also has a number of important methodological limitations. Obviously, the central methodological limitation to this study is the use of a role-played client. Because the client played a role, we did not focus on the client's experiences of the sessions at all. We focused exclusively on the therapists. But because the therapists were fully aware of the role playing, they were also role playing what they would have done if the client had been a real client. That is evident from the 12 reflections we put in domain 5 (see Appendix - the category of the therapist's awareness of the artificiality of the situation). Given the therapist's awareness of the artificiality of the session, the question can be posed how different their therapeutic actions and their reflections would have been if this was a session with a real client. This is a serious limitation of this research and we suggest that a replication with real clients is called for, provided, of course, that an acceptable solution is found for some of the ethical challenges this kind of research with real clients poses.

Another major methodological limitation involves the small number of participants, and perhaps even more importantly, the lack of diversity of the therapeutic setting. Indeed, as family therapists, we feel that there is a need for a replication of this study with couples or families, instead of with individual clients.

A third significant methodological limitation lies in the procedure of the tape assisted recall, that can not be considered a perfect recording of a therapist's reflections. When therapists put their reflections into the computer there is a selection. Some things the therapist felt or thought during the session were not mentioned in the tape assisted recall notes. For instance, there are surprisingly few reflections on own life, personal history (3.1.1.4.). Also, in the feedback session with the participating therapists, some therapists reported that some of their thoughts about their personal life were not put into the laptop because at that time they did not seem relevant. This fits with what some participating therapists had confided to the researcher immediately after the tape assisted recall session, during an informal talk over coffee. They mentioned reflections they had during the session but that they did not put into the computer. One therapist, for instance, remarked that during the session he was struck by the attractiveness of the doctoral student who played the role of the client. He had not mentioned this, however, in his tape assisted recall notes. Asked why he had not put these reflections in to the computer, he offered the unlikely explanation that he did not think the researcher would be interested in these thoughts! Another reason therapists refrained from mentioning some thoughts and experiences in their recall notes is probably that some thoughts and experiences did not seem to fit, in the sense that they were not coherent with the reflections the therapist had given so far.

It is well known in narrative psychology that people aim at some level of coherence in their self stories, and that this can make them selective in their relating of personal experiences

(e.g. Carr, 1986; Baerger & McAdams, 1999; Fiese, 2002). It seems that this also played a role in our research. The evidence that at least some of the therapists have withheld remarks is an important limitation of the study. What it points out is that what we have really studied is not the therapists' inner conversations, but the therapists' inner conversations that the participating therapists were willing to talk about in the given context. It is a challenge for further research to try to find ways to get at some of these reflections left unspoken in our research. Although there will always be things left unsaid, regardless of the research procedure used, we hypothesize that the rather standardized, experimental design of our study (asking therapists to put in their reflections in a computer, for instance) may be responsible for this problem. Also, the general design of the study, as well as the rigorous procedures we used to check the reliability of the coding processes, may have added to the artificiality of the study, leading to a rather general and formal model of the therapist's experiencing. For future research, we think that, for instance, sensitive qualitative face-to-face interviewing (instead of using a laptop as we did in our research), would give the researcher the possibility to better tune into the therapists' own stories and this would help to reduce these problems considerably. Also, given the general model generated in this present study, in future research more specific research questions could be addressed, which would make room for more substantive and specific understandings of the therapist's experience in the session.

### ***Further Implications***

Our basic research question was exploratory in nature and formulated as: "What is the content of the therapist's inner conversation during the therapeutic session?" All in all, our research has made us appreciate the wealth of the therapist's inner conversation as is evidenced

by the broad range of the therapist's reflections we have found in our data. Another general conclusion we can draw from our data is that the therapists in our study are very concerned to be in tune with the client's expectations, preferences and vulnerabilities. The therapists seem to prefer to consider their work as a kind of dialogue, in which they mainly look for ways to collaborate with their clients. This fits with the finding of conversation and discourse analysts that there is a general preference for agreement and politeness that rules most conversations in our culture (Pomerantz, 1984; Chilton, 1990). But more specifically, it also fits with a general orientation of therapists towards a collaborative therapeutic relationship of good quality. As most therapists know that a good therapeutic alliance is associated with good outcome, they attend closely to the relationship with their clients and evaluate its quality throughout the session.

Possibly, this research might play a role in the context of the discussion of the concept of *not-knowing* that is currently so important in the family therapy field (e.g. Larnar, 2000; Guilfoyle, 2003; Rober, 2005; Anderson, 2005). The concept of *not-knowing* seems to suggest that 1. what is on the therapist's mind is a kind of knowing (theory, hypotheses, certainty,...) (Anderson, 1997; 2005), and 2. that this knowing is a kind of "expert-power" that has to be kept in check to protect the client from being colonized (Anderson, 1997). What our research seems to show is that there is a very broad spectrum of thoughts, feelings and ideas on the therapist's mind (not only theory, expert knowledge, and so on), and also that the therapist is focused on being in tune with the client's preferences, expectations and vulnerabilities. Although the concept of *not-knowing* is interesting and has a lot of merits, our research seems to highlight some of the limitations of the concept. The concept makes room for the expertise of the client but it does not address the complexity of the therapist's experience of therapy. It emphasizes the

importance of knowledge and the way in which therapists use it (Anderson, 2005), but other aspects of the therapist's experiencing are left out in the shade by the concept, which is a pity because as a consequence these aspects of the therapist's experiences risk to remain unspoken in training and supervision contexts.

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## **Appendix: Overview of Categories**

### **Domain 1. Attending to client process**

- 1.1 Reflecting on the personal process of the client
  - 1.1.1. Monitoring the client's reflecting
  - 1.1.2. Evaluating the client's reaction to the therapist
  - 1.1.3. Feeling/sensing the experiencing of the cl
  - 1.1.4. Assessing the evolution of the client
  - 1.1.5. Monitoring the cl's storytelling
- 1.2. Trying to understand the client's expectations
  - 1.2.1. Trying to understand what the client needs
  - 1.2.2. Trying to find out what the cl wants to talk about
  - 1.2.3. Trying to understand what the cl expects from therapy
- 1.3. Process observations
  - 1.3.1. Describing what he/she is observing
  - 1.3.2. Giving meaning to the nonverbal behavior of the cl

**Domain 2. Processing the client's story**

2.1. Assessing the client in her stories

2.1.1. Evaluating severity

2.1.2. Noticing resources

2.2. Hypothesizing

2.2.1. Hypotheses about the couple relationship

2.2.2. Hypotheses about the person of the client

2.2.3. Hypotheses about the client and his/her family

### **Domain 3. Focusing on therapist's experience**

#### 3.1. Emotion experiencing

##### 3.1.1. Awareness of own experiencing

3.1.1.1. Client focused emotions

3.1.1.2. Self focused emotions

3.1.1.3. Emotional impact of session

3.1.1.4. Reflecting on own life, own family, own history, ...

3.1.1.5. Reflecting on mental image/metaphor

##### 3.1.2. Reacting on own experiencing

3.1.2.1. Sharing with client

3.1.2.2. Pushing oneself

3.1.2.3. Disconnect/avoid

3.1.2.4. Looking for something to hold on to

3.1.2.5. Relying on the familiar

#### 3.2. Instructing him/herself explicitly

3.2.1. Instructing about managing the self

3.2.2. Instructing about therapeutic actions

3.2.3. Warning him/her self for possible difficulties

3.2.4. Reminding him/herself not to forget

3.2.5. Instructing re: focus

#### 3.3. Managing own thinking process

3.3.1. Tracking/reformulating what the client says

3.3.2. Observing own thinking process

3.3.3. Own personal views and values

3.3.4. Mentally reaching outside the session

#### 3.4. Addressing the client implicitly

**Domain 4. Managing the therapeutic process**

## 4.1. Optimizing the context

## 4.1.1. Managing the therapeutic space

4.1.1.1. Dealing with the client's expectations

4.1.1.2. Reflecting on therapeutic contract

4.1.1.3. Reflecting on the therapeutic relationship

4.1.1.4. Protecting the therapeutic space

## 4.1.2. Considering the practicalities of the session

## 4.2. Considering/describing therapeutic actions

## 4.2.1. Therapist's positioning in the session

## 4.2.2. Stimulate the cl's exploration

4.2.2.1. Put some pressure on client

4.2.2.2. Redirect client

4.2.2.3. Stimulate client's reflection

4.2.2.4. Confront

## 4.2.3. Support client

## 4.2.4. Information gathering

## 4.2.5. Providing new interpunction

## 4.3. Planning/reflecting on interventions

## 4.3.1. Considering different courses of action

## 4.3.2. Setting up a therapeutic intervention

## 4.3.3. Considering the stages of the session

## 4.3.4. Predicting effect of intervention

## 4.3.5. Evaluating therapeutic actions

## 4.4. Assisting in the telling of the story

## 4.4.1. Managing room to talk

## 4.4.2. Trying to find out what words to use

## 4.4.3. Topic focusing

4.4.3.1. Avoiding topics

4.4.3.2. Approaching topics

**Domain 5. Reflections of the artificial situation**