

POSITIONING IN THE THERAPIST'S INNER CONVERSATION: A DIALOGICAL MODEL BASED ON A GROUNDED THEORY ANALYSIS OF THERAPIST REFLECTIONS

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In recent years, a dialogical perspective has emerged in the family therapy field in which the therapist's inner conversation is conceptualized as a dialogical self. In this study, we analyze the data of a grounded theory study of therapist reflections and we portray the therapist's self as a dynamic multiplicity of inner positions embodied as voices, having dialogical relationships in terms of questions and answers or agreement and disagreement. We propose a descriptive model of the therapist's inner conversation with four positions. In this model, each of the four positions represents a concern of the therapist: attending to the client's process, processing the client's story, focusing on the therapist's own experience, and managing the therapeutic process. Detailed analyses of vignettes of therapist reflections illustrate the model, and implications of this model for training and supervision are considered.

In recent years, a dialogical perspective has emerged in the family therapy field (e.g., Rober, 2002, 2004, 2005; Seikkula, 2002; Seikkula & Olson, 2003). In this view, inspired by Bakhtin's concept of the dialogical self as a polyphony of inner voices (Bakhtin, 1981, 1984; Morson & Emerson, 1990), some family therapists have described the therapist's self as an inner dialogue (e.g., Andersen, 1995; Anderson, 1997; Anderson & Goolishian, 1988; Rober, 1999, 2002, 2005). This dialogue has been called the *therapist's inner conversation* (Rober, 2002, 2005).

Describing the therapist's inner conversation as a polyphony of inner voices suggests that the therapist's self be considered as dialogical in nature (Hermans, 2004a, 2004b; Rober, 2005). Referring to William James's classical distinction between the *I* and the *Me* (James, 1890), this dialogical self can be portrayed as a multiplicity of I-positions (Hermans, 2004a, 2004b): it is "a dynamic multiplicity of (voiced) positions in the landscape of the mind, intertwined as this mind is with the minds of other people" (Hermans, 2004a, p. 176). Hermans (2004b) describes the self in spatial terms: ". . . self as being composed of a variety of spatial positions and as

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related to positions of other selves” (p. 18). According to Hermans, the I moves from position to position, as in a space, depending on the context: “The I fluctuates among different and even opposed positions. The voices function like interacting characters in a story. Once a character is set in motion in a story, the character takes on a life of its own and thus assumes a certain narrative necessity” (Hermans, 2004b, p. 19).

Hermans’s use of the spatial metaphor “position” is important here. “Positioning” focuses on the dynamic aspects of encounters and replaces the traditional concept of “role,” with its static, formal, and ritualistic connotations (Davies & Harré, 1990): “With positioning, the focus is on the way in which the discursive practices constitute the speakers and hearers in certain ways and yet at the same time is a resource through which speakers and hearers negotiate new positions” (Davies & Harré, 1990, p. 14). Taking the positioning concept out of the confines of the interpersonal domain, and extending it for use in the intrapersonal domain, Moghaddam (1999) uses the term “reflective positioning” (p. 74), referring to the process by which persons position themselves in unfolding personal stories told to oneself in inner conversation.

In earlier publications, based on our work as clinicians and trainers (Rober, 1999, 2005), we used the concept of the dialogical self to describe the therapist’s inner conversation, and we distinguished therapist inner voices reflecting the position of the therapist’s experiencing self from inner voices reflecting the position of his or her professional self:

1. *The experiencing self* refers to the therapist observations of the immediate situation as well as the memories, images, and fantasies that are activated by what the therapist observes. In a sense, the experiencing self implies a here-and-now not-knowing receptivity towards the stories of the client, as well as towards what is evoked by these stories in the therapist.
2. *The professional self* includes the therapist’s hypothesizing (Rober, 2002) and his or her preparing of responses in the session. From an observer position towards the experiencing self, the therapist tries to make sense of his or her experiences by structuring observations and trying to understand what is going on in the family and in the conversation.

In this way, we have described the therapist’s inner conversation in broad strokes as a dialogue between the position of the experiencing self and the position of the professional self (Rober, 2005). The dynamic interplay between inner voices parallels the therapist’s actions in the outer conversation with the client, sometimes finding expression in questions or interventions, while at other times suggesting silence, thus remaining unspoken or unexpressed in the outer dialogue.

In this article, we extend our exploration of the therapist’s self as an inner dialogue using some of the data from a grounded theory analysis (GTA) of therapist reflections. We chose this approach because it is widely practiced, flexible, and allows some mild organizing influence from existing theory. It is quite similar to methods that have been used successfully for similar kinds of data (e.g., by Rennie, 1990, 1992, 1994). The method is consistent with contemporary family therapy theory because, at least in some variants (e.g., Charmaz, 2006), it is broadly constructivist and hermeneutic while still recognizing the importance of careful analysis. We refer to our previous publication (Rober, Elliott, Buysse, Loots, & De Corte, 2008) for a more detailed discussion of the method and general findings of this study. In this publication, we will use the data of this study to develop a clearer perspective on the therapist’s inner voices, and on the different positions from which they speak. Before we focus on the therapist’s inner conversation, however, it may be necessary to outline the results of our grounded theory study of therapist reflections.

A GROUNDED THEORY STUDY OF THERAPIST IN-SESSION REFLECTIONS

Setting

We studied the reflections of therapists during sessions with a role-playing client who presented with personal, relational, and family problems. The role-played sessions were recorded on

videotape in a video room in the psychology faculty building at Ghent University (Belgium). In this study, 12 experienced family 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 12 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, in 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 female 19-year-old university student who had phoned for an appointment. She presented with personal as well as family difficulties. The therapists were asked to do a first session with this client, as if the client wanted therapy in an outpatient clinic setting. The sessions lasted between 30 and 40 min.

Ethical Issues

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, and the study was approved by the university. In order to protect the confidentiality of the participating therapists, they were 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.

Video Recording

The role-played session lasted between 30 and 40 min and was videorecorded. After 30 min there was an auditory signal to the therapist indicating that it was time to bring the session to an end. The therapist then took a few minutes to finish the session, make a new appointment, and say goodbye. Then we used a tape-assisted recall procedure (Elliott, 1986; Kagan, 1975). Tape-assisted recall procedures are commonly used in process research (e.g., Elliott, 1986; Gale, Odell, & Nagireddy, 1995; Rennie, 1994; Rober, Van Eesbeek, & Elliott, 2006) as a way to access the client's or therapist's experience of the therapeutic session. In our study, 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 or she was experiencing during the session. Every 45 s the tape was stopped and the therapist was asked to put into a laptop computer all thoughts, feelings, and experiences he or she recalled he or she had at that point in the session. It was made explicit to the therapists that they did not have to give retrospective reflections, but that they should try to recall what they had experienced 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 Master students under supervision of the first author. The first author added the notes of the 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. In this study, we analyzed the tape-assisted recall notes made by the therapist.

Grounded Theory Analysis

Grounded theory analysis was used to analyze the transcripts of the recall sessions. Here we were inspired by the work of David Rennie, who did a GTA of the client's experience of a

psychotherapy session (Rennie, 1990, 1992, 1994). We wanted to do the same for the experience of the therapist. GTA was originally developed by two American sociologists, Barney Glaser and Anselm Strauss (Glaser & Strauss, 1967) as a general method for developing theory that is grounded in data systematically gathered and analyzed (Strauss & Corbin, 1994). Rather than testing preexisting 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, undertheorized domain (Burck, 2005; Charmaz, 1995; McLeod, 2001).

Data Analysis

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. Descriptive categories were identified and then the constant comparison method (Glaser & Strauss, 1967; Strauss & Corbin, 1998) was used, constantly comparing meaning units and categories for similarities and differences. This method was used on all transcripts one by one until theoretical saturation was achieved: this means that the analysis of a new transcript did not generate new categories, or did not help to elaborate on existing categories (Charmaz, 2006; Strauss & Corbin, 1998). The constant comparison of the data 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 domains, that is, broad organizing categories. These domains form a general formal framework for the phenomenon under study.

External Auditors

As a check on the trustworthiness of the first author's analysis, an auditing process was used (Hill, Thompson, & Nutt-Williams, 1997; Rober, 2004). Three experienced researchers from three different universities (Robert Elliott, Ann Buysse, and Gerrit Loots) were external auditors who reviewed the analyses of the first author and provided feedback. When the first author finished his coding of the meaning units, he made a detailed report to one of the auditors (Elliott) in which the category system was presented and all categories were described, including all meaning units (in Dutch with English translations) assigned to categories. This 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 to make sure (a) that they fit the category they were located in and (b) that they did not also belong somewhere else. The original transcripts of the sessions were used as reference in case the auditor needed to look up something that did not make sense out of context. Then the first author used the auditor's feedback to modify the category system and the assignment of meaning units. Then he made a new report incorporating the comments and suggestions of the auditor. That report was sent to all auditors (Robert Elliott, Ann Buysse, and Gerrit Loots). They reviewed it independently from each other and gave feedback to the first author. This was used to construct a final report, incorporating the feedback of the three auditors. This report was then sent to the auditors for their final approval.

RESULTS

The Categories

In the GTA, theoretical saturation was achieved after analyzing the transcripts of eight (randomly selected) of the therapists. The transcripts of the other four therapists were not used in the analyses but were later used to check on the completeness of the category structure. A total of 1,074 codes have been assigned to the 906 meaning units in the eight transcripts. Our study resulted in a taxonomy of 282 different codes in a hierarchical tree structure of six levels.

The list summarizing the main categories can be found in the appendix. Four general domains of categories of reflections have been distinguished:

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 or her responsibility as a therapist: taking care of the therapeutic context, assisting the client in the telling of his or her story, and reflecting on therapeutic interventions. The therapist is focused on what he or she can do in order to help the client.

A 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 a core category in its own right, in that each appears to be essential for the therapist to function effectively in the session. As result, we gave up searching for a single core category and, instead, we focused on the development of a general descriptive model of the therapist's inner conversation that connects the four main domains (see Figure 1).

It is useful to see Domains 1, 2, and 3 as parallel tracks. They seem to be different but interwoven communication channels: the emphasis is on the perception and processing of information. Domain 4 is different. The emphasis in this domain is on integrating and managing

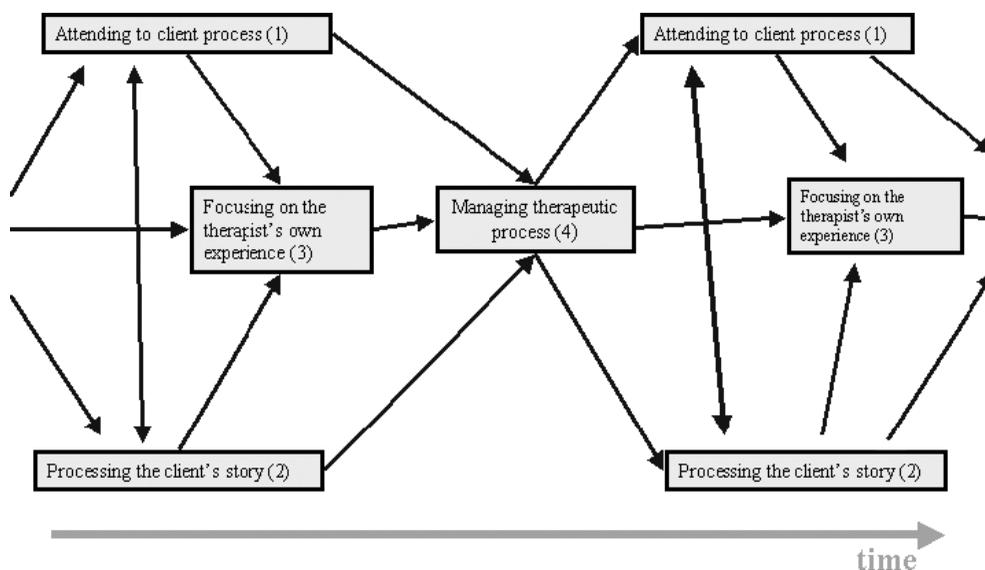


Figure 1. The general model of the therapist's inner conversation.

information from the three sources of observation (client's process, client's story, therapist's experiencing). Domain 4 is explicitly action oriented and comprises the therapist's commitment and efforts to use this information in the outer conversation in order to help the client (by establishing a safe therapeutic space, assisting the client's storytelling, and carrying out useful interventions).

The four domains are connected with each other in various 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 each category of reflections can come first, but each 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 by the client that can be observed; however, it can also be the last step in a process that starts with listening and observing, followed by experiential integration, leading to reflections on what to do next.

What's Unexpected?

It is interesting to compare the findings of our GTA study with what we wrote in the past years on the therapist's inner conversation from a perspective of a family therapist or a family therapy trainer (Rober, 1999, 2002, 2005). In general, this model seems to confirm some of the ideas about the therapist's inner conversation, as proposed in earlier publications (Rober, 1999, 2002, 2005). In qualitative research this poses the problem of trustworthiness. Finding what you expect might mainly uncover the researcher's biases, instead of really adding to our understanding of the phenomenon under consideration. Therefore, we should look more closely, and focus on what is new and unexpected in our findings. Have we gained more understanding of the therapist's inner conversation if we compare our finding with ideas that were published elsewhere and that we originally formulated? What did we find that we did not expect? What did we not find that we did expect?

When we make such a comparison, it could be said, for instance, that domain 4 has some resemblance with what we called the "professional self" in one of our clinical articles on the therapist's inner conversation (Rober, 2005). In that article, we described the therapist's professional self as "the therapist's hypothesizing . . . and his/her preparing of responses" (Rober, 2005, p. 489). In contrast with what we wrote in 2005, however, in the model we developed in this GTA study, the therapist's hypothesizing belongs to domain 2 (the processing of the client's story). Only the therapist's preparing of responses is part of domain 4. Furthermore, our research adds to our understanding of the therapist's inner conversation, as it indicates that the therapist's reflections on the management of the therapeutic process (domain 4) mainly consists of reflections about optimizing the therapeutic context (category 4.1), about assisting the client in the telling of his or her story (category 4.4), and about therapeutic interventions (category 4.2 and category 4.3).

While domain 4 has some resemblances with "the professional self," the other three domains together resemble the "experiencing self" (Rober, 2005). Rober described the experiencing self as "the observations of the therapist as well as the memories, images, and fantasies that are activated by what the therapist observes" (Rober, 2005, p. 489). As we noted above, in contrast to the 2005 paper, an important part of domain 2 (the processing of the client's story) consists of the therapist's hypothesizing. Furthermore, our research helped us to have a more detailed understanding of what the experiencing self is, as it points out that the "experiencing self" can be thought of as consisting of three main aspects: the therapist's attending to the client's process (domain 1), the therapist's processing of the client's story (domain 2) and the therapist's focusing on his or her own experiencing. Furthermore, our research helps us to understand, for instance, how exactly therapists deal with their own experiencing in the session. It shows that therapists try to be aware of their emotions (category 3.1.1), and they try to do something with them (category 3.2.1). In addition, therapists manage their own thinking

process: observing their thinking process, being aware of their state of knowledge, as well of their own personal views and values.

Summarizing, we can say that our GTA study helped us to move from a model with two main positions in the therapist's inner conversation (position of the experiencing self and position of the professional self) to a more complex model with four positions: attending to the client's process, processing the client's story, focusing on the therapist's own experience, and managing the therapeutic process. This, in fact, represents a model of the therapist's inner conversation as a complex process organized around two dialectics: client vs. therapist focus and content vs. process focus. Furthermore, this model highlights that in the inner conversation the therapist is not only focused on the story told by the client. It is a fuller explication of the extent and manner in which the therapist is occupied by his or her experience of the client. Our model is not built around the metaphor of the therapist as the "heroic, all-knowing savior" in therapy. Instead, it recognizes the therapist's dialogue with the client as the center of the therapeutic process (Rober et al., 2008). It appears that our previous model may have been too "therapist-centered," thus underestimating the role of the Other in the lived in-session experience of the therapist. In our new model of the therapist's inner conversation, the client is portrayed as a true dialogical partner: active (Bohart & Tallman, 1998), if not heroic (Duncan & Miller, 2000), in connecting with the therapist, and participating in the flow of talk. The therapist is portrayed as primarily focused on tuning in to the client and on creating a space together with the client in which they can explore the client's life and suffering, and search for new hope and possible change (Rober et al., 2008).

Using the lens of this new model, let us now look more closely at some of our data in this study, and see what we can learn about the inner conversations of the therapists.

SOME KEY FEATURES OF THE THERAPIST'S INNER CONVERSATION

Self-Talk

While we have proposed a descriptive model of the therapist's inner conversation (Rober et al., 2008), in our data, therapists only sometimes explicitly address themselves in their inner conversations (category 3.2). In six of the eight transcripts this kind of self-talk can be found. Some therapists even use their own Christian names (here replaced by pseudonyms) to address themselves.

Two examples:

Mrs. Orange 2.15 ". . . walk on eggshells, Sarah, . . ."

Mr. Black 11.30 "Don't talk too long, Leo."

Self-talk is not new to psychotherapy process researchers, who found that it is one strategy experienced therapists use to manage their self-awareness (Williams, Polster, Grizzard, Rockenbaugh, & Judge, 2003). In our data self-talk seems to be mainly a kind of self-instruction in which the therapist is telling himself or herself what to do next, or what to focus on. At other times the therapists warn themselves of possible difficulties or remind themselves not to forget things. These are very overt examples of a dialogical self in which two parts of a person seem to be in an inner conversation: one more reflecting voice, speaking from a certain distance, addresses a more action-oriented voice that seems to be closer to the outer conversation with the client. These explicit inner conversations seem to help the therapist to decide what to do.

The Therapist's Inner Conversation

While therapists sometimes explicitly address themselves in their inner conversations, often it is not obvious who is addressed by these voices. Sometimes a reflection seems to be the expression of one monolithic thought or idea responding to whatever the client says or does, as

if it is one inner voice speaking from one specific position. Often, however, a therapist's reflections present themselves as a sequence of different thoughts. In those cases, we can recognize different inner voices, each speaking from a different position, voicing a different concern, sometimes even contradicting each other. These inner voices respond to voices in the outer conversation, but they also respond to each other: questioning each other, disagreeing or complimenting each other, each representing different positions the therapist can take or different concerns the therapist might have. As Hermans (2004b) writes, dialogue is possible only when there is difference: "the mind is able to entertain a meaningful internal communication, only if the answering part is to some extent *qualitatively different* from the asking part" (Hermans, 2004b, p. 14, italics in the original). Only in cases where there is difference between the positions from which the voices speak can the dialogical character of therapist reflections be observed.

By way of illustration, let us return to the GTA data and consider this excerpt of the session of Mrs. Orange (see Table 1). The transcript of the session is presented in the left column. The therapist's inner conversation (the therapist's entry at 13 min 45 s in the session) is presented in the right column.

This example of an inner conversation of a therapist illustrates the dialogical view of the therapist's self: different inner voices, speaking from different I-positions, responding to each other (Hermans, 2004a). Each position can be distinguished as a separate inner voice questioning the previous voice, commenting on it, reinforcing it or disagreeing with it. In fact, it is possible to discern seven different parts within this one example of therapist inner speech:

- 1: "Wrong, she hears herself saying that she went to live in rooms because of her parents! That is unacceptable." [Alarmed, self-questioning]
- 2: "Do something, Sarah!" [Urging, self-instruction]
- 3: "What?" [Requesting help]
- 4: "Don't let this feeling and this impression exist in her!!" [Empathic with the client, self-instruction]
- 5: "Think, think, . . ." [Urging to come up with a solution, self-instruction]
- 6: "shit," [Expressing frustration]
- 7: "broaden" [Offering solution]

We can't be sure that these are seven different inner voices. Probably they are not, as it seems that parts 2, 4, and 7 might actually be the same voice. They might be speaking from the same position, as they seem to convey the same general message, and seem to push the therapist in the same direction ("do something"). What's more important here, however, is that the therapist's inner conversation in this example clearly illustrates the general idea of the therapist's dialogical self. While one inner voice is speaking, the therapist is listening to her own inner voice, and a new voice is activated to comment on the first voice, to criticize it, to compliment it, to question it. In that way, every voice is feedback for another voice, inner or outer. In this example, for instance, the first voice is alarmed when she observes that the client does not accept her own words she has just spoken. Another voice, more action oriented, instructs the therapist to do something. A third voice asks, "But what should I do?" "Try to change the way she feels," the action-oriented voice seems to answer. This voice pushes the therapist to come up with a solution. Finally, a solution is suggested by a voice urging the therapist to "broaden the discussion!" Each of the therapist's voices is a reaction to a previous voice, taking a new position, reflecting another concern. Finally, in the outer conversation with the client, the therapist not only broadens the discussion, but she also focuses on the process in the here and now, questioning the client about how it feels for her when her therapist talks about her home and her parents.

When we look more closely at the therapist's inner conversation in this excerpt, we notice that the therapist's different voices can be categorized in different domains of therapist reflections

Table 1 <i>Example of a Productive Therapist Inner Dialogue: Session Transcript and Therapist Reflections</i>	
Outer conversation	Inner conversation
<p><i>Therapist:</i> . . . Going to the college city, living in a student's apartment, was it . . .</p> <p><i>Client:</i> It was not easy.</p> <p><i>Therapist:</i> Not easy?</p> <p><i>Client:</i> No, it was really difficult.</p> <p><i>Therapist:</i> Did you choose your apartment yourself? Or did you do it together with your parents?</p> <p><i>Client:</i> Together with my parents [. . .] I have hesitated a lot about going to live in [. . .] but I thought it was better . . . I could be more on my own.</p> <p><i>Therapist:</i> That's what made you decide to live in a student's apartment, instead of staying at home?</p> <p><i>Client:</i> It is so strange, it is as if we are implying that it is bad at home, I don't want to give the impression that, well yes, it sometimes is difficult (13.45) and yes, when I say I went to live in a student's apartment because at home is a hell, and that it is an escape, and so on.</p> <p>There are also practical reasons to live in a student's apartment, because of the train, and so on . . .</p> <p><i>Therapist:</i> If you would get the impression that I consider it an escape or something, I have to tell you I don't see it like that . . . I wouldn't want you to have that impression . . . [. . .] Can I ask you something?</p> <p><i>Client:</i> Yes.</p> <p><i>Therapist:</i> When I talk about your home, or when I talk about your parents, is that difficult for you?</p> <p><i>Client:</i> Hoh, no, euh, maybe that is why I come in therapy</p>	<p>(13.45)</p> <p>Wrong, she hears herself saying that she went to live in rooms because of her parents! That is unacceptable. Do something, Sarah!^a What? Don't let this feeling and this impression exist in her!! Think, think, . . . shit, broaden</p>
<p>^aThis is a pseudonym.</p>	

(see the appendix) as they were constructed in our GTA study (Rober et al., 2008). These are the different voices in our example and the domains in which they can be categorized:

- Wrong, she hears herself saying that she went to live in rooms because of her parents! That is unacceptable (*domain 1 and more implicitly domain 2*)
- Do something, Sarah! (*domain 3*)
- What? (*domain 4*)
- Don't let this feeling and this impression exist in her!! (*domain 4*)
- Think, think, . . . (*domain 3*)
- shit (*domain 3*)

- broaden (*domain 4*)

This illustrates that in the therapist's inner conversations, there are movements back and forth between voices attending to the client's process (domain 1), voices processing the client's story (domain 2), voices dealing with his or her own experience (domain 3), and voices focusing on the therapeutic process (domain 4). Viewed in this perspective, each of the four domains seems to represent a different concern of the therapist in his or her work with the client (see Table 2).

The voices expressing the therapist's different concerns respond to each other: questioning, disagreeing, and complementing each other's utterances. The therapist's inner conversation, then, can be considered a field of tension between different concerns, in which the dialogical situation (the client's story as well as the current dialogue with the therapist) is assessed (domains 1, 2, 3) and, through the interaction between the inner voices, a gradual move is made towards therapeutic action (domain 4). The therapist's mission, then, is to find ways to deal with the tension in this inner dialogical space with its four main I-positions, in such a way as to be helpful for the client. Ideally, there should be a fluent dialogue between the different positions. Not one of these positions should be dominant, and there should be room for all voices. The tension between the different positions, then, is an opportunity to enhance the creativity and resourcefulness of the therapist.

Table 2 <i>The Four Domains of Therapist In-session Experience as Centers of Therapeutic Concern</i>	
Name of the domain (see the appendix)	Therapist's concern
1. Attending to client process	<i>"Where is the client in the dialogue?"</i> The therapist reflects on the personal process of the client in the here and now of the session, trying to understand the client's expectations and making process observations.
2. Processing the client's story	<i>"What is the client telling me?"</i> The therapist tries to make sense of the client's story by means of hypotheses about the client's person, life, and relationships. Furthermore, the therapist assesses the client in his or her stories, evaluating severity and noticing resources.
3. Focusing on the therapist's own experiencing	<i>"Where am I in the dialogue?"</i> The therapist is aware of his or her own experiences in the session. Furthermore, he or she manages his or her thinking process, and instructs himself or herself on what to do.
4. Managing the therapeutic process	<i>"How can I help the client in his or her process?"</i> The therapist reflects on potential therapeutic actions and plans them. The therapist optimizes the therapeutic space to make room for the client's story, and assists the client in the telling of his or her story.

However, this is often not evident. Therapists sometimes get stuck in this tension. Then they experience an impasse, feeling disempowered in their therapeutic role (Flaskas, 2005). Let us give one example to illustrate this. From our experience as supervisors, we learned that therapists can sometimes feel paralyzed when they experience strong emotions during the session with the client. A therapist we will call Judy, for instance, found herself feeling very angry towards her client. What bothered her most was that she could not listen empathically to the client's story any longer: everything the client said seemed to add to her anger. She felt powerless, and didn't know how to be helpful to the client. She told her supervisor: "Therapists should understand, they should not be angry towards their clients." Judy had not been able to find a way out of this impasse, and in supervision it became clear that she was so impressed by the destructive potential of her anger towards the client that she felt paralyzed and had not allowed herself to reflect on ways the anger might be constructively used for the benefit of the therapeutic process. Judy felt stuck, and so it became the supervisor's task to find ways to help her make room for this inner voice, and to consider possible ways to use this voice in a nondestructive way in the therapeutic process (domain 4).

Similarly, in our data here we find instances illustrating that dealing with their own experiences (for instance, strong emotions) is not always easy for therapists. In the next example (see Table 3), the therapist (referred to as Mrs. White) searches for a way to deal with her nervousness at the start of the session. Again, in the left column is the transcript of the session, and in the right column are the therapist's reflections (in this case, at 45 s in the session).

This is the beginning of the session. Both the client and the therapist seem to be hesitant to start the conversation. The therapist's inner conversation in this example illustrates how the

Table 3 <i>Example of a Therapist Inner Dialogue: Session Transcript and Therapist Reflections</i>	
Outer conversation	Inner conversation
<p><i>Therapist:</i> [. . .] Well, good afternoon. Is it the first time you have come to this therapy center?</p> <p><i>Client:</i> Hmmm.</p> <p><i>Therapist:</i> Hmmm, yes, I don't know if you have an idea about where you are or how a therapy center works?</p> <p><i>Client:</i> Na, no, not really. It is just the doctor who gave me this address and telephone number. The lady just said that I had to come here at this time and for the rest</p> <p><i>Therapist:</i> Oh, yes, OK. (00.45)</p> <p>Maybe I will briefly explain about this center and how it works and, euh, maybe if you also . . . euh, you can pose me the question you have . . .</p> <p><i>Client:</i> Ah yes, OK.</p>	<p>(00.45)</p> <p>I feel tense. I think it is important to make a good start and especially that the client feels at ease with me as much as possible, so she can tell her story. I will try to find something to hold on to in my usual way of starting off with clients (explaining something about a therapeutic center and how things will proceed).</p>

therapist tries to master her own nervousness and be useful to the client's process. We will now analyze this excerpt, referring to the general model we described above in Figure 1. As noted earlier, the four domains in our descriptive model are operationalized as an organization of different I-positions of the therapist, from which her inner voices speak (Hermans, 2004a). The therapist notices that she feels tense (domain 3—Focusing on the therapist's own experience). She wants to make a good start (domain 4—Focusing on the therapeutic process), and she wants to put the client at ease so she can tell her story (domain 4—Focusing on the therapeutic process). The therapist decides to start the conversation in the way she is used to, in the hope that that might help her to be less tense (domain 3—Focusing on the therapist's own experience). The therapist's main concern seems to be to find a way to make room for the client's story (see also Rober et al., 2008). She wants to make sure that her own nervousness does not jeopardize this mission. So she moves from a position of experiencing her own nervousness (domain 3) to the position of how to manage the therapeutic encounter (domain 4) and back again to a position of dealing with this nervousness (domain 3) in such a way that the client's room to talk is safeguarded.

This example illustrates that in the therapist's inner conversation each position can be distinguished as a separate inner voice speaking, dealing with a different concern. Moreover, this example also illustrates that the therapist's inner conversation reflects the therapist's attempts to master her nervousness, in order to be helpful to her client: struggling with making sense of what happens in the session (domain 1), with what the client recounts (domain 2), and with what she experiences herself (domain 3), all the while asking herself what to do next in order to be useful in the client's therapeutic process (domain 4). So although the dialogical self is decentered and comprises a multiplicity of inner voices, it is not fragmented or chaotic. Rather, it has some coherence and some organization, in such a way that it fits in with its social and cultural context (roles, expectations, norms, etc.) in which the therapist functions (Hermans, 2004b). When in this study we focus on the therapist's inner conversation, the social context in which the therapist's dialogical self takes shape refers in the first place to the therapist in his or her role as therapist, and to the social expectation that he or she is helpful to the client in distress. Indeed, as Moghaddam (1999) writes, positioning cannot be considered in isolation of the social and cultural context. It always takes place in a context of a specific moral order in which the voices are active: "societal and cultural norms are reflected in the internal dialogue and, by implication, in the relative dominance of the conflicting or alternative voices" (Hermans, 2004b, p. 17). In our study, the context in which the therapist's inner voices emerge is a context of psychotherapy in which the therapist is expected to be helpful to the client in distress. This is explicitly reflected in the importance of position 4 in the therapist's inner conversation. In position 4, the main concern of the therapist's inner voices seems to be "What *will I do* in order to help the client?" This means that voices of position 4 are action oriented ("What will I *do* in order to help the client?"), future oriented (cfr. the future tense of "What *will I* do in order to help the client?"), oriented to the therapist's own agency ("What will *I* do in order to help the client?"), and client oriented ("What will I do in order to help *the client*?"). Indeed, position 4 implies the empathic extension of the therapist's self to the client as the therapist weighs the potential effect of his or her questions and interventions on the client's process.

CONCLUSION

Based on our GTA study of therapist reflections (for a more detailed discussion of the method and general findings of this study, see Rober et al., 2008), in this article, we have proposed a dialogical model of the therapist's inner conversation. Previous writers, such as Hermans (2004a, 2004b) and Stiles (1997, 1999), have emphasized client multiplicity; we have tried to extend this perspective to the therapist. We have portrayed the therapist's self as a dynamic multiplicity of inner positions embodied as voices, having dialogical relationships in terms of questions and answers, agreement and disagreement, and so on (Hermans, 2004a).

In comparison with our earlier writing (Rober, 1999), this article represents a move forward in two major respects: the first move has to do with our use of the term “position” to characterize differences between inner voices. “Positioning” is a dynamic metaphor that offers us the possibility to highlight the differentiation of inner voices, localizing them in time and space, not as things or parts but instead as vantage points, implying that the world is always seen from a particular vantage point, and not from another. The concept of “positioning” helps us better describe the dynamics of the dialogical self, where one voice comes into being in dialogue with another voice. It also helps us to describe the therapist’s inner conversation, enriching our thinking about the complexities of therapeutic relationships.

Secondly, we moved from a relatively simple model of the therapist’s inner conversation as a dialectical process with two main positions from which inner voices can speak (the experiencing self and the professional self) to a more complex model with four positions. In this new model, each of the four positions represents a concern of the therapist: attending to the client’s process, processing the client’s story, focusing on the therapist’s own experience, and managing the therapeutic process. The model highlights the importance of the dialogue with the client for the therapeutic process, as the therapist’s first concern is with tuning in to the client and with the dialogical creation of a space to talk in which the client can tell his or her story.

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 needed to focus on particular aspects of the therapist’s inner conversation, particularly in terms of the specific processes in the therapist’s inner conversation in family therapy, in comparison with individual therapy. 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 (Rober, 2005), 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. 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, which cannot be considered a perfect recording of a therapist’s reflections. When therapists put their reflections into the computer there is a selection. 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., Baerger and McAdams, 1999; Carr, 1986; Fiese, 2002). It seems that this also played a role in our research. 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.

Perspectives

In many respects, this new model offers us potentially rich perspectives for the future. In terms of training and supervision, we already hinted in this article at some of the implications of our model. While these implications will be discussed in more detail in publications to come, in general, we can say that our model proposes that psychotherapy training, among other things, should also be aimed at helping therapists to deal with the tension that exists between the four main I-positions of the therapist. In the supervision of therapists at stuck points, our

study suggests that the central question is in which way the tension between the main I-positions in the therapist's inner conversation can be used to promote the dialogue with the clients and, ultimately, the therapeutic process of these clients. In terms of research, a potentially highly productive line for further investigation may be to look at therapist dialogue at stuck points in order to identify the differences between productive and unproductive therapist inner dialogue. Identifying key places where therapists become stuck and useful strategies for extricating themselves from such stuck places could turn out to be quite helpful for both experienced and inexperienced therapists and their supervisors.

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APPENDIX

THE CODE SYSTEM: SUMMARY OF THE MAIN CATEGORIES

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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 client
 - 1.1.4. assessing the evolution of the client
 - 1.1.5. monitoring the client's storytelling
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- 1.2. Trying to understand the client's expectations
 - 1.3. Process observations
 2. Processing the client's story
 - 2.1. Assessing the client in his or her stories
 - 2.2. Hypothesizing
 3. Focusing on the therapist's experience
 - 3.1. Emotion experiencing
 - 3.1.1. awareness of own experiencing
 - 3.1.2. reacting to own experiencing
 - 3.2. Instructing himself or herself explicitly
 - 3.2.1. instructing about managing the self
 - 3.2.2. instructing about therapeutic actions
 - 3.2.3. warning himself or herself of possible difficulties
 - 3.2.4. reminding himself or 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
 - 3.3.3.1. feeling own needs/preferences
 - 3.3.3.2. expressing own view
 - 3.3.4. mentally reaching outside the session
 - 3.4. Addressing the client implicitly
 4. Managing the therapeutic process
 - 4.1. Optimizing the context
 - 4.2. Considering/describing therapeutic actions
 - 4.3. Planning/reflecting on interventions
 - 4.4. Assisting in the telling of the story
 5. Reflections of the artificial situation
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Note. For an overview of all 282 categories, we refer to Rober et al. (2008).