STRIKING MOMENTS IN DIALOGIC EXCHANGES FROM A SYSTEMIC THERAPIST PERSPECTIVE

Tanya Carmen Chetcuti

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A dissertation presented in part fulfilment of the requirements for the Degree for the Professional Training in Systemic Family Therapy (Masters Level)
DECLARATION OF AUTHENTICITY

I hereby declare that this dissertation: “Striking moments in dialogic exchanges from a systemic therapist perspective”, which is being submitted to the Institute of Family Therapy (IFT) Malta, is solely the work of the student Tanya Carmen Chetcuti as supervised by Mr. Joseph Mangion.

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Tanya Carmen Chetcuti
Masters level Student

______________________________

Mr. Joseph Mangion
Dissertation Supervisor
I would like to take this opportunity to thank my supervisor Mr. Joseph Mangion for knowing when to connect with me and when to let go. His respectful and gracious presence and support throughout this research process and my training was deeply appreciated and invaluable.

I wish to also extend my gratitude to the Institute of Family Therapy Malta for their belief in me even when I doubted myself and for waiting for me until I could find my place of safe connection.

A special thank you goes to all the research participants who gave of their time and of themselves to facilitate this research study.

To my peers, I cannot really put into verbal expression, just how much your presence in my life during this research process was of meaning to me. You held me and sustained me and reassured me that all would be well. I am indebted to you.
In the spirit of connection… in Indian Hindu culture, there is a custom that is sometimes expressed as Namaskar or Namaskaram, this is a customary greeting when people meet or depart. Namaste is “spoken” with a slight bow and hands pressed together, palms touching and fingers pointing upwards, thumbs close to the chest. This gesture in Hindu means,

“I bow to the divine in you”
To those in absentia whom I could not reach, I carry you with me always.

To Rocco and Mila Amani, my beloved ones, and my hope.
ABSTRACT

This qualitative study explored the lived experience of systemic family therapists during moments of connection in therapy with clients. A purposeful sampling strategy was adopted to ensure that all participants were practicing systemic family therapists adequately qualified. The data was collected using semi-structured interviews and analysed using Interpretive Phenomenological Analysis. Seven superordinate themes surrounding human connection, the therapeutic use of self, resonance, and the embodiment process in therapy emerged. Which were, “Connection as a firstly human endeavor”, “Therapists have internal calling to become therapists”, “Attunement to the embodiment process”, “Is connection felt or seen?: therapists’ perspective”, “Resonance with life scripts”, “Meaning making: The search for truth”, “Seeing the past: to let it go”. The results were discussed within the realms of a social constructionist, dialogical framework.

Key Words: Connection, Dialogical, Use of Self of Therapist, Embodiment Process, Resonance, Therapeutic Process, Therapeutic Alliance, Social Constructionism.
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Chapter One
1.1 Preamble

Throughout my life, I have searched for a sense of security and belonging, and this has been a personal motivator in my own quest for connection. As a young child, I remember in particular when I would go home on the bus from school, I would often find myself looking longingly into other people’s homes and windows whenever it had a rosy warm light in it. It was almost as if the glow emitted from the lamp represented to me the welcoming greeting of family and connection that says to you, don’t worry, you are home now safe and sound. Perhaps, my own yearning to find “home” and connection was rooted here?

Many years after these events, and during my quest to find myself once more, I entered into personal therapy, and in a restful conservatory filled with plants that served as my therapist’s clinic, right there between us in the window sat another old fashioned gas lantern with that same cheery glow. Amidst the comfort of its light, many conversations of connection and transformation took place between us, some of which will remain with me always.

These therapeutic moments became embedded and stayed with me I think because it was often in these intense yet fleeting moments that we shared that it felt as though we were just two human beings humbly navigating our way through life’s questions, and all seemed at par and imbued with hope.

In time, as my development progressed, my life story eventually wove its way into the tapestry of my career choice, and I became a trainee psychotherapist myself, and clinically I was also very intrigued by how this same tenuous relationship that I had with connection impacted my clinical practice and training. Perhaps because, thematically in my own background, various insecurities had been present and this had deprived me of emotional trust and left deep psychic wounds which I often struggled with in my therapeutic role.

Timm and Blow (1999) state that it is the therapist’s predisposition to reflect on personal issues that influence the therapeutic process both in a positive and negative manner. Whilst Haber and Hawley (2004) highlight that the continuous presence of
ghosts from therapists’ family of origin can impact both their personal and professional conduct. Aponte et al. (2009) caution that therapists must be aware of their own life journey so that they manage to keep an emotional distance that allows them to challenge clients and not become organized by the emotional turbulence they present.

From my ghosts, I learnt that for me being connected also meant feeling vulnerable and disarmed at times, and this was often experienced by me as alienating and unsafe. Oddly enough, and rather ambiguously, from these reflections I began to notice that in the work I tended to experience moments where I felt cautious and wary of intimacy in the relational sense, perhaps because in these highly intense therapeutic moments it sometimes felt as though my core was being “invaded” by clients, and yet at the same time, I deeply craved and had this primitive longing and yearning to belong and be with too.

My therapeutic embodiment process often mirrored this sense of dislocation and disorientation, as it often felt as though I was standing outside of my own body nervously looking in at myself. This became most apparent to me in particular when I was confronted with families who presented with the same isomorphic processes to my own, and these testing moments where I had to juggle my own emotional reactions coupled with those of the clients were actually what helped to expand my thinking. This instigated an interest in me discovering more about how I could better use these emotional reactions in therapy with clients to forge healthier connection.

It seemed that the more clinically immersed I became in this process, the more I also began to appreciate how one of the most important “job requirements” of a skilled and effective therapist was to be able to embrace, tolerate and stay with many different kinds of emotional states on a daily and often hourly basis, and yet find a way to remain grounded and connected to both themselves and their clients throughout this arduous process.

In this regard, Haber (1990) suggests that if used well the personal reactions towards family dilemmas presented in practice that are similar to their own can be “keys to use and enter and understand the analogic, relational, symbolic processes within the client and therapeutic system” (p. 377). Whilst Satir (2013) speaks of the clinical
importance of the therapist needing to have processed their own issues, lest they run the risk of becoming lost and misleading the clients further.

Along this therapeutic path of certainty and uncertainty, I found myself in touch with the thinking and practice of postmodern and social constructionist ideas, and these concepts helped support me to liberate me from the confinement of these personal and professional insecurities. Thus I was enabled to conceptually understand more about this very tenuous complex relationship that I had with connection and how this could be used more constructively in therapy.

From these things, I learnt hands on the importance for the therapist to be mindful of situating their own lived experiences contextually in their positioning and work with clients. According to Jensen (2008), psychotherapy that takes into account, both the personal and private elements of a therapist’s abilities is thought to be a more complete experience. Recently, there has been an interest in situating theory and clinical work in the therapist’s wider context (Mason et al., 2003) including “culture, values and spirituality” (Aponte et al., 2009, p. 382) and this could be indicative of the way forward for contemporary family therapeutic practice.

So, it was this originally obscure relationship, based primarily on these contradictions and polarities within myself therapeutically, that led to me widening my conceptual lens and thinking differently about how to engage and sustain contact with clients in the work. Systemic positioning enabled me to maintain a curious stance, and, in due course, through my self-reflexivity and integration process, I was gradually able to form a more coherent story about how my past experiences influenced my epistemology and practice regarding connection and the therapeutic change process.

Fundamentally then, these thoughts and reflections were what laid the foundation for my wish to research and delve deeper into this particularly ambiguous aspect of the therapeutic relationship and how transformational moments of connection take place in therapy. Thus, the following chapter elaborates on the area of study and in various stages presents the rationale for its development into a research project.
1.2 Research Rationale.

This study is a qualitative investigation exploring spontaneous moments of connection in therapy, and how as systemic therapists these are merged in our dialogical conversations with clients. I hope to show through this aspect of the therapeutic relationship how these dynamics are also mutually constructed, and as such, are influenced by connection in the relational context.

The idea of a mutually constructed relationship “made” by therapist and client together has been widely documented and explored by several authors, particularly by conversational, dialogical therapists such as Anderson (2007), Seikkula (2002); Seikkula and Olsen (2003), and Rober (2005). I also hope to convey how these ‘striking moments’ (Lowe, 2005) may ameliorate the process of change in therapy, thus being able to shed more light on how these factors may be of benefit to both the therapist and the client alike in terms of facilitating growth.

Postmodern ideas and social constructionist positioning have influenced the way that therapy is thought about and undertaken, and this shift has meant that clients now play a far more active role in their own therapeutic journey. Aponte and Carlsen (2009) argue that the idea of holding a more collaborative therapeutic stance with clients may also be a reaction to wider societal changes, where, as personal constructs, freedom to express oneself and choice are given precedence over social conformity.

With regard to the formation of a more shared therapeutic experience a consistent finding in psychotherapy research is that in terms of the therapeutic fit, the quality of the therapeutic alliance is one of the best predictors of psychotherapy outcome (e.g. Bachelor and Horvath, 1999; Martin, 2011; Orlinsky et al., 2005). ‘Positive therapeutic outcomes are robustly predicted when therapists are experienced as being personally engaged rather than detached, collaborative rather than directive, empathic, and warmly affirming’ (Orlinsky and Ronnestad, 2005, p.179). This seems to be true for psychotherapy in general, and for family therapy in particular (Blow et al., 2007; Carr, 2005; Sprenkle and Blow, 2004).
It would seem then that from the therapists’ perspective, these adjustments in our positioning with clients has also led to a more in depth focus on our use of self in our meetings with families. Recent writings in the family therapy area highlight self-of-the-therapist work as a crucial foundation and pediment to the formation and development of therapists (Baldwin, 2013; Rober, 2011; Satir, 2013). Perhaps this may be because, in terms of developing a stronger therapeutic alliance an awareness of self seems to be fundamental in engaging and connecting with clients and the overall change process in therapy.

According to Jensen (2008), although self-of the-therapist work has been recognized as a critical element in the psychotherapist’s development, there seems to be a research gap on how their personhood and experiences influence the therapeutic process. He argues, “this omission is in line with the central idea in evidence-based practice that it is the therapy that works and not the therapist” (Jensen, 2008, p. 375).

Moreover, Flaskas, (2012) spoke of an increased awareness of the role of reflexivity and reflective practice in therapeutic work with families, and how through further scrutiny into the therapeutic relationship, therapists might be more able to develop and support themselves further through a deeper awareness of their own process and how this may help to build a better therapeutic alliance with their families in practice (Senediak, 2014).

Another raison d’être for this piece of research is tied up with a wish to understand more about how I could put to better clinical use my own emotional reactions with clients in order to engage with them further in therapy. These thoughts are heavily influenced by Rober’s (2011) ideas about the emotional aspects of therapy, where he articulates how at a core level, it is often these emotionally tense situations which are considered therapeutically unbearable for therapists, and that fall within the “not able to share” category of our therapeutic undertakings, that also represent, in all earnest, a brutally frank therapeutic snapshot of the totality of some of our clinical experiences. Therapeutically, perhaps these dark fearful spaces may offer the potential for opening up more collaborative and connective conversations with clients if they are looked into more. Rober (2011) points out how these difficult instances may be tied up with the credence given to valuing the therapist’s humanity.
in the session, and exploring the importance for the therapist to have this space for honest reflection (e.g. Elkaïm, 1997; Flaksas, 2005; Larner, 1996, 2004).

Another major reason for defending and wishing to explore more this emotional focus in the work, is because it could also be helpful to consider how family therapy work is different to individual client work. Apart from the emotional bombardments placed upon the therapist when working with one client, family therapists also have to contend with the sheer volume of emotionally intense activity in the room due to the presence of various family members and their varied emotional states in sessions. This could indicate that from this hectic place, all kinds of troubling feelings like: fear, sadness, helplessness, anxiety and so on (Aveline, 2005) may be elicited. It would seem then that often family therapeutic practice for the therapist is first and foremost a question of how to (emotionally) survive the session (Wilson, 2007). Rober, (2011) suggests that it is only once we have mastered this ability that we can then pose the question as to how we can better position ourselves therapeutically in such a way as to be helpful to the family, in the full knowledge that therapeutic change is still an uncertain territory and one that cannot be forced or coerced into being, but that can at best be encouraged through an authentic use of self.

With regard to positioning and the change process in therapy, in my experience as a trainee therapist, change often occurs in the strangest and most innocuous of ways, and it’s sometimes when two or more human beings simply find mutual ground for understanding, and often has very little to do with theoretical underpinnings. Larner (1998) describes the territory of change eloquently as follows: ‘This is where the therapist stands: outside therapy while inside, and with a sense of humility and astonishment when change occurs’ (p. 567).

1.3 Relevance of this Study.

This study aims to contribute towards a deeper relational understanding of the therapeutic experiences of systemic psychotherapists during moments of connection with clients. It also intends to shed more light on how the phenomena of connection may ameliorate the process of change in therapy and how this may be of
benefit to both the therapist and the client in terms of facilitating growth. One reason for this is because there seems to be limited research on which specific family therapists’ variables influence their clinical practice and outcomes (Blow, Sprenkle, & Davis, 2007; Holmes, 2006; Jensen, 2008). The intention being that through a more in depth dyadic understanding of this aspect of the therapeutic relationship, therapists could adapt their positioning further with clients/families to better support and encourage them in their therapeutic journeys.

These factors seem to indicate a need for family therapists to be skilled at personal reflection and this has been seen in the increased attention to the role of reflexivity in practice with families (Flaskas, 2012). This reflexive focus may in turn, support them to have a more refined clinical understanding of the mutual processes taking place between themselves and their clients in the work (Senediak, 2014).

Bearing in mind the wider context, supervisors and trainers might also benefit from any findings elicited from this study, and these may shed much needed light on this relatively forgotten area of family therapy. Whilst the findings in this study will not be able to be generalised, one hopes that, through the narratives of the participants, more insights and awareness can be offered on this area of research that could be of benefit to therapeutic understanding.

Finally, and from a local perspective, as far as I am aware, there has not yet been a qualitative research carried out in this particular area, so there is a research gap around this phenomenon and anything that could shed light on this would be both apt and timely.

1.4. Self –Reflexivity

As previously outlined, throughout my life, my own relationship with connection and change for various reasons has been a fearful insecure one, and during my training and research process, this was compounded by the fact that I was also going through some challenging and alienating life events connected thematically to my area of research. As I wrestled with isolation, change and the
solitary nature of the research process, I was forced to confront certain personal questions which had plagued me throughout this journey. During this time, it felt as though I was going through what I can only describe as some form of parallel connective/disconnective process of my own, and as I struggled to reconnect with connection I became more and more curious to explore how these thematic similarities in my personal and professional life could be used to further expand and develop my research thinking.

Questions arose like, how being a therapist was often hard for me because of this inner struggle to be “with” whilst also standing “alone”, and how holding on to “self” whilst embracing “other” remained an unreachable ideal for me professionally. From these uncertainties and impasses, I realised that being with “other” in “relationship” whether personally or professionally could at times be both comfortable and awkward for me, perhaps because, to become “one” with clients I first had to make myself vulnerable. As I surrendered myself defenselessly to the therapeutic moment just as earnestly as my clients did, I found myself entering the private perceptual world of another human being whilst trying desperately to hang on to my own perceptions and my therapeutic integrity.

Related to these thoughts, I also began to see that probably even my choice to become a psychotherapist was very much tied up with this duality, in that holding a therapeutic role somehow managed to satisfy these two diametrically opposed aspects of my personality. Being a therapist legitimately “allowed” me to feel both deeply connected to a human being whilst at the same time remaining somewhat “inaccessible” through the structure and safety provided by therapeutic boundaries and the clinical framework. Thus, at times, therapy felt like I was walking on an emotional tightrope, fraught with misunderstandings, both about myself and my clients, and from this disenfranchised remote place I often found myself split and confused.

However, as a budding systemic therapist, I painfully and sometimes rather reluctantly, began to learn how to oscillate between being relationally present and collaborative with clients, whilst standing just enough outside of the same space to be able to offer clarity and direction to them. Along this road, my supervisors
encouraged and supported me to cultivate this clinical ability to drift in and out between these two often alien worlds where boundaries and connection could exist simultaneously. Initially, I experienced these attempts at shifting me along professionally as badgering and invasive, and thinking about these things from a social constructionist perspective, I can further appreciate how I was being encouraged to develop an ability to foster and maintain relational depth. This type of positioning in the work required a type of fluidity that asked me to move away from my fixed assumptions and engage more fully with what was “out there” in the world (see Cooper, 2010a). When I allowed myself to engage with what was outside of me I gradually began to experience safe connection.

In terms of connection in therapy, it is pertinent to mention the importance of clinical support because current systemic literature stresses the importance of professionals being able to connect their personal process with their theoretical underpinnings and orientation in training. Aponte and Winter (2013) expand upon these thoughts by further claiming that training clinically is a demanding enterprise that is necessary for practitioners to develop their skills and competence. In their opinion, it helps with the linking of academic and theoretical notions to be implemented in practice. This made me realise just how many complex layers of connection form part of our work as therapists.

Another way that I managed to connect and synthesise these reflections more concisely was through an understanding of how my own “signature themes” (Aponte & Carlse n 2009, p. 397) and episodes of loss and connection affected me in the work. Clinical reflexivity helped me to develop a richer contextual understanding of how these factors impacted me in terms of my therapeutic collaboration with clients in therapy. I learnt to fully appreciate the importance for family therapists to reflect on their relational patterns and identify how they can hinder them from forming and sustaining healthy therapeutic relationships (Aponte, 1994). These daunting learning shifts were in essence what fuelled my need to know more about connection and change in the therapeutic setting.
1.5 Conceptual Framework.

Any discussion on a conceptual framework is perhaps first better contextualised by how one understands one’s theoretical and practice based knowledge and positioning. In qualitative research several experts equate theory with the methodologies used in conduction of a research and the epistemologies underlying them (Denzin and Lincoln, 2005). According to Denzin and Lincoln (2005, p. 30-32), paradigms equate with theory and bear the researcher’s “epistemological, ontological and methodological premises” which direct the conducts of a researcher. In this way, the researcher “approaches the world with a set of ideas, a framework (theory, ontology) that specifies a set of questions (epistemology) that he/she examines in specific ways (methodology, analysis)” (Denzin and Lincoln 2005, p.36-37). The variety and wealth of theoretical frameworks give researchers a valuable opportunity to see what could seem familiar through a new and distinct perspective.

The body of existing theory and practice that informs this research project is concerned with postmodern and social constructionist positioning and epistemologies, where through the lens of social construction, the emphasis is shifted from the individual, to the individual in social interaction (Gergen, 1985,1989). The aim of this particular framework, being one housed in social constructionism and postmodern ideology is to tentatively offer an understanding of how moments of connection may come about in therapy, and may eventually help to enhance the therapeutic change process. Dialogical understanding will also be considered as a possible theoretical framework to enrich the understanding of the lived experiences that will be shared by the participants.

1.5.1 Postmodernism

Postmodernism is an intellectual movement that represents in essence a rejection of modernism which gave rise to much debate and questioning about preconceived notions to do with humanity and its search for truth. There was a shift from single realities and absolutes to the possibility of multiple realities, and the formative role of language and culture in giving meaning to experience. Sociological influences
included the thoughts and writings of Kant, Neitzche and Marx, who despite other differences, held the common view that knowledge was in part a product of human thought rather than exclusively grounded in external reality. These ideas were also rooted in how sociocultural forces construct knowledge, and this led to a later interest in symbolic interactionism by authors such as Mead and Blumer.

A postmodern approach also compliments the stance of this study as it creates a time of complexity and ambiguity where there are competing versions of inquiry (Mac Intyre, 1990). The introduction of postmodernism and the reality of multiple truths heralded a welcome and much needed shift in professional thinking and positioning with families, and with therapists themselves. Adopting this position, will allow me the possibility as researcher to understand the participant’s accounts, and in this way, I will be provided with the chance to include my own paradigms.

1.5.2 Social constructionism.

Social constructionism contends that knowledge is socially co-constructed and, belongs to all people (Burr, 2015), and that knowledge is culturally and historically bound and, thus, determines a set of beliefs which influence persons within a stipulated society, and the discourses which influence how individuals and societies experience specific events, play a major role in how expectations are lived within particular cultures (Burr, 2015).

There are four main tenets that make up the stance of inquiry concerned with social constructionism, these mainly translate to, a critical stance in relation to the construction of how knowledge is arrived at, a cultural and historical component, and about how knowledge is sustained through social process such as those of interaction and language, how knowledge and social action go hand in hand through meaning making. By focusing on this importance of everyday life and connections between people, social constructionism places a clinical focus on language and how meaning is generated through this.
Social constructionism is deemed appropriate as the theoretical point of departure for this study because from a relational perspective, its philosophy suggests that dialogue is the means through which self and the world are created (Gergen, 1999). Thus, I am privileging these accounts because there is no one individual way to identify a social constructionist position (Burr, 2015). This also helps to create a relational understanding of how the world does not function in any one absolute way (Doherty, 1999.) This line is in keeping with the stance of this study which will not focus on one objective reality, but will attempt to give voice to the multitude of ways that the participants give meaning to their own therapeutic experiences, and how they perceive that they influence relational connection and the change process.

Through combining a postmodern constructionist framework, as the researcher I also hope to highlight how these factors have given family therapists a flexibility to recognise the variety of ways in which their clients view their world (Moules, 2000). On a personal level, this approach also resonates with my current relational understanding of therapy and is one in line with the position of second order cybernetics (Von Foroester, 1996). From this perspective, it is assumed that the observer is not separate from what he/she observes, but in fact, co-constructs their reality with the observed, and is influenced to intervene or develop therapeutic strategies or interventions from this place of therapeutic meeting or encounter.

1.5.3 Dialogical Understanding

“...Truth is not born nor is it to be found inside the head of an individual person, it is born between two people collectively searching for truth, in the process of their dialogic interaction”. Bahktin, (1984a, p.110).

Dialogical practices have their origins in the philosophical underpinnings of Kant, and operate in the domain of social relations and are theoretically based on the assumption that human existence itself is relational and that the dynamics of the subjective coincide with, or even are preceded by, the dynamics of the intersubjective (Seikkula, 2011b; Erdinast Vulkan, 2008).
Dialogical practices have been widely described from theoretical perspectives, (e.g. Rober, 2005; Seikkula, 2011a, 2011b; Shotter, 2010, 2012) and their clinical application to couple and family therapy (Rober, 2008, 2010). The dialogical aspects of change in family therapy have been explored through analysis of the dynamics and qualities of the actual dialogue (Seikkula, 2012).

Dialogical understanding is based upon a mutual respect in therapy, through an awareness of the client’s needs and pace, and in terms of therapeutic process, dialogical therapy is not thought of in stages but more as a continuous engagement progression through its focus on language and interactional relational and embodied dynamics.

Dialogical “interventions” are more to do with the exchanging and discussion of ideas and processing of feelings. Therapeutic conversations from this perspective are more concerned with creating spaces that possess the ability to bind or to connect people, and they also contain an emotional focus. The creative emotional aspects of conversing were elaborated upon by Walter and Peller (2000), and Bird, (2000) who spoke of listening for all that reverberates in the room.

Dialogical listening involves attempts at listening out for things that may not be able to be said at home but can be shared in therapy. Through responsive listening, ie listening that acknowledges and validates the client’s position one can facilitate them to tell their story differently. Rober (2016) described this aptly as “you connect then you step back” (verbatim).

As a concluding comment to this conceptual framework, and before reviewing existing literature in the next chapter, around connection and the change process in therapy, one needs to ask a very important question which is: “Can something as elusive as connection be qualified in the first place?” Connoley (2009) said in this regard, “it’s like butterfly catching, isn’t it? –there’s a fear of catching something very beautiful and trying to define what it is, and then, and in that process, losing what it is”.
With these thoughts in mind, a focus in particular on the relational aspect of therapy will be examined, particularly with regard to the special moments of connection in therapy that we are privileged to experience in our work as therapists.

1.6. Layout of the Study

After introducing the aims of the study, Chapter 2 will attempt to provide an overview of the most pertinent literature that supports the relevance of this study. Chapter 3 will present a detailed description of the methodology selected including the rationale behind the research design chosen and the data analysis procedure used in this study. In Chapter 4, the analysis of the common themes emerging from the interviews will be presented. Then will follow a discussion of the findings linked to the available research and literature in Chapter 5. The final and concluding chapter, Chapter 6, will give an overall summary of the study with its limitations and proposed recommendations for future research.
Chapter Two
Chapter 2: Literature Review

2.1 Introduction

An exploration of existing literature shows that within the early years of family therapy there were certain areas which had been neglected, namely those of the therapeutic relationship and the emotional experience within that relationship (Flaskas, 1997). More recently, in this regard, Dallos and Draper (2000, p. 23) commented that the early use of systems theory offered, “both a compassionate view of individual experience but also a reductionist and possibly mechanistic one” (as cited in Flaskas, 2009). Perhaps because of these early “reductionist” ideas, during the formative period of systemic therapy, a space was opened for therapeutic practices that challenged the highly individualised and pathologised practices of that time. This ushered in a move away from this modernist worldview which emphasised linear thinking, to a postmodern emphasis on recursive, perceptual, and relational thinking (Flaskas, 2009).

As way of setting a context of sorts for this research, I would like to tentatively “define” striking moments in therapy, and also provide a small description regarding the change process in therapy.

2.2 What are Striking Moments in therapy?

Striking moments in therapy refer to what Shotter and Katz (1998) called a “language of momentary doings” (p. 89). In these instances, the focus is on remaining present and engaged in the moment, and as the therapeutic conversation unfolds, there is an avoidance of theoretical organisation, impositions or hypotheses. The therapist’s activities remain internally responsive as opposed to externally driven. Shotter and Katz (1998) cleverly use Tom Andersen’s therapeutic work to honour this stance, describing the careful attention paid to listening out for striking moments that are “living”, “poetic” and “arresting”. These take place when speakers or listeners are visibly touched or when something seems to hang suspended or arrested in the momentary spaces between utterances. As Katz and Shotter (1996) put it, each arresting moment also provides a resting moment for reflection and
further exploration that allows clients to “gesture” toward the uniqueness of their lives.

2.3 The concept of change in the process of therapy.

The concept of therapeutic change and what ameliorates this process in therapy has been widely documented. One factor that was identified was what is known as the “common factors” perspective and this has been articulated extensively in various academic publications (Duncan et al., 2009; Hubble et al., 1999; Sprenkle & Blow, 2004; Sprenkle et al., 2009).

The main findings of this research being that there appears to be four groups of factors related to positive therapy outcomes: the strengths and resources that clients bring with them to the therapy, including all the fortunate factors in their lives promoting change; the placebo effect, or clients' capacity for hopefulness about the therapy; the therapeutic alliance and relationship-mediated variables in the therapeutic process; and, finally, the specific techniques and models used in the therapy (Hubble, Duncan & Miller, 1999, as cited in Flaskas, 2010).

Interestingly, Beisser (1970) in his “paradoxical theory of change” put forward his belief that if one is to be “transformed”, then one must totally immerse oneself in one’s process first if change is to take place. In his view, one must first surrender to what one is, if one is to grow, as often change occurs through acceptance.

2.4 The literature Research Strategy.

A thorough search was conducted to identify any literature that looks into the therapeutic relationship vis a vis connection and the change process in therapy. Multiple online databases and a research library were utilised in this research, and as a consequence, this search yielded a number of results, which were looked at, and the most relevant literature deemed suitable for the purpose of this study was selected. In carrying out this process, a number of other sources were detected, which in turn were used as a foundation for further research to take place. The
citations and references present within these sources were looked into and further themes were elicited.

2.5 Clinician researcher gap

Studies within family and couple therapy challenge the belief that the method is the main component in change, and point to the need for qualitative studies that can help to identify the multitude of factors involved in the process of change (eg. Blow et al., 2009, Blow, Sprenkle & Davis, 2007; Pinsof & Wynne, 2000; Sprenkle & Blow, 2007). Clinician researcher gap in the family therapy field is a significant concept (Sandberg, Johnson, Robilla & Miller 2002, Sprenkle & Moon, 1996). Pinsof and Wynne, (2000) state couple and family therapy research is often too distant from the actual therapists’ experiences and does not provide meaningful information for affecting treatment.

2.6 Dialogical Understanding and its Implications on Therapeutic Practice.

As way of providing a preliminary short introduction to this segment of my literature review, I would like to offer a small historical outline of how dialogical understanding came about, and who were some of the main protagonists in its creation. I would also like to humbly assert that my style of writing in this regard will be to tentatively try to capture the essence of the associative elements along this trajectory, as way of complimenting the overarching theme of this piece of research which is fundamentally that of connection.

2.6.1 Bakhtin and the Dialogical Language Focus

Various philosophers and thinkers have contributed to the development of dialogical understanding, but perhaps, the most known and the first stance that informed the field was that of the 20th century Russian philosopher and literary critic, Mikhail Bakhtin (1895-1975). Although, in fairness, many others have also given a richer understanding and contextualisation of the relational process of therapy, and some of these other contributions will be examined too.
One of Bakhtin’s first preliminary observations was that nobody can fully have sense of their own suffering, because they cannot see themselves from the outside. In his own words, nobody can see ‘the clear blue sky against the background of which his suffering outward image is delineated for me’ (Bakhtin, 1923–1990, p. 25). Thus, according to Bakhtin (1986), dialogical understanding is an active, responsive process that originates from participation in conversations, and requires the presence of another human being.

Anderson and Goolishian’s paper on “human systems as linguistic systems” (1988) is rooted in Bakhtin’s previous ideas on the “multiplicity of voices” that reside within each and every one of us as human beings. The dialogical notion of the creation of the creative space in therapy is connected to attempting to provide the means for allowing as many voices as possible to be heard and to be present in the session, even if this means, a growing discordance of the family’s voices plus all their individual voices too. Amidst this process sits the voice of the constructionist dialogic therapist who is also present thus adding to the richness of such an experience.

Central to this conceptual shift was the notion that human systems are language meaning—generating systems (Anderson & Goolishian, 1988), or as Gadamer (1975) had postulated earlier on, “we are conversational beings” with others later adding, “that we are dialogical selves” (Bernstein, 1983, p. 104). Therefore, “the work of therapy has to do with exploration of these meaning systems through conversation”. (Anderson, Goolishian, & Winderman, 1986, p. 5). Collaborative language systems, is based on the belief that therapists are contributors to the meaning making of clients in therapy (Anderson, 2005).

### 2.6.2 Bakhtin’s influence on psychotherapy

From Bakhtin’s (1975) perspective, “for the world (and consequently for a human being) there is nothing more terrible than a lack of response” (p. 127). Respecting the dialogical principle in therapy that every utterance calls for a response in order to have meaning, but from this perspective, answering does not mean giving an explanation or interpretation, but rather, demonstrating in one’s
response that one has noticed what has been said, and when possible, opening a new point of view on what has been said. From a dialogical perspective, this is where reality happens and it is only from this place that true healing can take place.

### 2.6.3 Buber’s influence on dialogical understanding

“We looked into the hearts of each other’s eyes” (Buber, 1947, p.5-6).

Another main contributor to the field of dialogical creativity is Martin Buber (1873-1965), and I first began to familiarise myself with Buber’s works and philosophy perhaps because I initially connected with his particular style of aesthetic writing, and positioning, and I found that this freedom afforded me an ability to conceptualise clinical scenarios in a less sterile way. His writing also resonated with my own preferred way of expression, as Buber’s hand was often thought to be poetic and mystical, and indeed, this was often thought to be symbolic of his greater desire for the pursuit of another form of relating in the world.

Buber, as quoted by (Hodes 1971, p.23) encapsulated a “poetry of the everyday” and perhaps this was why Buber’s thinking was embraced by so many disciplines including, health, education, psychology and ethics. Buber’s voice dominated the relational process of therapy, and fundamentally his work has been described as an ethos, or way of being human and relating to one’s world.

Like others, I found that my own questions and my own need to overcome personal struggles within the area of connection were somehow appeased and soothed by Buber’s writings (Jacobs, 1991). His ideas quelled my professional insecurities like balm to a wound, and so it was easy for me to recognise how Buber’s rhetoric spoke so elegantly about “deeply felt yearnings for genuine engagement with others.” (Jacobs 1991). In this imitable way, he brought about a focus in me on the relational process in therapist-client or research-participant encounters, and this led to the developing a deeper and more practical understanding of the many nuances involved in these processes.
In his seminal paper *I and Thou*, Buber (1937) described a dialogic philosophy of relation, and the *I-It* relation of subject-object, and the *I-Thou* relation of subject-subject. Buber posited that the *I-it* position is where one responds to another as merely an object, or a means to an end, whilst in the *I–thou* position, we have the sophisticated stance of one encountering the other and meeting in the space that is shared in the realm that is created in “the between”.

Buber’s *I and Thou* were thought to conceptualise a model for engaging in the world, and through this, he thought that there was more to experiencing life through the senses, and that in fact there was what he liked to term the mode of the “encounter”. Buber went on to suggest a constant and indeed necessary movement between these two realms, not in temporal succession, but in an ever evolving “attitude of relation” (Buber, 1965, p. 62). Friedman (2012) asserts that Buber has been called a “dialogical existentialist” but Buber did not focus on the self, instead he “chose to privilege the relational while thinking existentially” (Czubaroff & Friedman, 2000, p. 246).

For Buber this positioning constituted all that is inter-human and real. Perhaps because, for him the inter-human aspect of connection is more than the sum parts of two people relating together it is in fact the very essence or soul of what exists between them (Buber, 1937). “All real living is meeting” (Buber, 1985 p.56).

### 2.6.4 Buber’s Influence on Psychotherapy

In psychotherapeutic terms, therapy and connection from Buber’s perspective can be thought of as the healthy and respectful response of authentic dialogue between a therapist and their client. Buber’s positioning translates to each moment with another person involving reciprocal change, where one is influenced by the other, as well as influencing and inviting the other to reciprocate. In therapy, Buber promoted a certain kind of relational contact where the therapist “meets” the client, “follows” the client’s experience, and does not aim for the client to be different. He spoke of how the therapeutic relationship should be reflective of “inclusion”, “authentic presence” and “commitment to dialogue” (Buber, 1937). A therapist who
is this is able to share self-doubts, limitations, feelings. But these must be done in the service of therapy. Therapeutic disclosure is a good example of this.

Buber, also felt that we have a need as humans to have our core existence confirmed to us by another. But this was not theorised by him on a superficial level, on the contrary, in terms of growth Buber surmised that it is only through our own ability to accept our own perceptions that we come to be fully understood and be able to connect with others. Therapeutically, in a similar fashion, the client becomes more likely to also develop a growth full and therapeutic attitude towards themselves and it is from this space through this mutual appreciation that forms the basis for the possibility of further connective moments to emerge.

In keeping with the postmodern conceptual framework of this research, this preferred stance in meeting with people put forward by Buber seems to also compliment a postmodern philosophy, possibly because the ideals contained in postmodernism such as deconstruction provide a way to challenge values and ideas that have been established as natural or absolute by society (Hare-Mustin & Marecek, 1998; Scott, 1990). For Derrida, (1980),

“deconstruction is neither a theory nor a philosophy. It is neither a school nor a method. It is not even a discourse, nor an act, nor a practice. It is “what happens”, what is happening today in what they call society, politics, diplomacy, economics, historical reality, and so on and so forth”.

Buber’s philosophy was also very much tied up with what happens when two people meet, and so is one committed to plurality and is one that discards the notion of the privileged standpoint (Allen & Baber, 1992). Buber’s ideas with their focus on what is happening between the therapist and the client also affirms from a feminist standpoint, the ethics of care spoken of by Gilligan (Johannsen, 2000) informs an overall feminist ethics (Walters, 2003) and supports an ethics of communication (Arnett, Fritz & Bell 2009). It is an ethical imperative to “respect whatever is before you and take it seriously. The reality before us is all there is: we must learn from what presents itself, whether wanted or not” (Arnett et al., 2009, p. 91).
As way of concluding this short review of Buber’s work I would like to bring to mind a small description by Hodes (1972), which I think captures the essence of what Buber was as a human being. After having had the pleasure of meeting Buber towards the end of the latter’s life, it was an encounter which left its mark dialogically on Hodes and it also said much about Buber’s preferred way of being in the world:

“He would meet me at the door… Our minds were on the coming talk… after we sat down there was always a silence- not a tense silence as between people who are not sure of each other, but a silence of expression… a prelude to speech. The silence was the silence of communication” (p. 14).

2.6.5 Humanistic Rogerian Perspective to Dialogical Understanding.

Further along the path of creative understanding, Carl Rogers who was the founder and leading voice of the humanistic movement in psychotherapy, felt that for dialogical understanding to take place the therapist is fully present, unconditionally accepting, empathic, and genuine (Rogers, 1957; Greenberg & Watson, 2006). In his opinion, it is qualities like these which allow and provide for genuine human engagement and contact that reduces clients’ feelings of isolation, increases the experience of being accepted and enhances interpersonal safety. This creates the optimal environment for focused attention to turn within. Along with this, therapists are in constant empathic attunement with clients’ affect and meaning. At all times, the therapist tries to make psychological contact with, and convey a genuine understanding of, the client’s internal experience (Rogers, 1951, 1957).

2.7 Current Systemic Perspectives on Dialogic Process in Therapeutic Work

At this point, I would like to provide a small resume that traces the evolutionary perspective of contemporary dialogically focused work. In this way, I hope to bring the current dialogical perspectives in to the discussion.
2.7.1 The Use of Self in Therapy

Over the last quarter of a century or so, within the field of family therapy, there has been an avid interest and focus on the therapeutic alliance in systemic work, and also on the use of self when working with families. In fact, this increased awareness led to various writings in clinical and theoretical areas that highlighted the major part that the self-of-the-therapist plays in the training and development of competent psychotherapists (Baldwin, 2013; Rober, 2011).

This attention to how the self is used therapeutically has its origins in the importance Freud (1958/1910) attached to the analyst going through a period of psychoanalysis during their training (as cited in Aponte & Carlsen, 2009). In doing so, the analyst concerned would evade their countertransference from obscuring the therapeutic process by taking charge of their own internal conflicts and issues (Satir, 2013).

Countertransference is one of the most significant and useful concepts in psychoanalytic theory and practice. Freud had a wary relationship with countertransference as he thought it to be a hurdle in therapy that was to be overcome. He asked that psychoanalysts aim for a state of ‘mental neutrality’ (Bolas, 1987, p. 201).

However, as psychoanalysts began to understand how this phenomenon could be harvested in therapy the view was revised and its merits were included for scrutiny within the therapeutic relationship between analyst and patient. In this way, these therapeutic departure and stumbling points could be considered as the preliminary gleanings of interest that heralded the start of a relational focus in the work.

This interest in the self-hood of the therapist was continued by the humanists/existentialists (Rogers, 1957) and through to the family therapy pioneers (Bowen, 1978; Satir, 2013; Whitaker & Keith, 1981). Another major contributor in this area was Bowen (1978) who made significant contributions clinically in this domain as he believed that the therapist’s own development was an important factor in engaging with clients. He referred to his own work to differentiate himself from his family of origin whilst training prospective family therapists to develop their own
differentiation. The focus on the personhood of the therapist was then continued by the postmodernists (Hoffman, 1990; White, 1993).

In contrast to the psychoanalytic field, the family therapy field didn’t give much attention to the therapist’s experiences in the session for some considerable time. At this time, the field suggested some general principles recommending how the therapist should position himself in the session with the family, such as neutrality (Selvini-Palazzoli et al., 1980), curiosity (Cecchin, 1987), and not-knowing (Anderson & Goolishian, 1992). In fact, after the postmodernist and narrative turn at the end of the 80’s, the emphasis was very much on the client’s expertise (Anderson and Goolishian, 1992), and later on this shifted to harmonizing with the client (Smith, 2004). Foucault’s thinking (Foucault, 1979, 1984), helped provide illuminations about how the therapist’s contribution to the therapeutic dialogue became uncertain, as it has the potential for colonizing clients and robbing them of their own voice (Rober and Seltzer, 2010).

But with the herald of the new millennium once more, the personhood of the family therapist started to reappear significantly and the stage was set for some theorists to begin to look at the dialogical character of the family therapeutic meeting (e.g. Andersen, 1995; Rober, 2005b; Seikkula and Olson, 2003), partly constructed as a result of their interest in the earlier works of Bakhtin (1981, 1984; 1986) and Volosinov (1973).

2.7.2 The Therapist as an Active Participant and Co-Traveller.

The basis of systemic work with families rests upon the foundation that family therapists are inevitably part of the system (Cheon & Murphy, 2007). This conceptual paradigm was highlighted fundamentally through the onset of the postmodern approach in family therapy and it was also namely responsible for the focus on the therapist’s use of self in that system. This was a rejection of the modernist position that relegated the family therapist’s role to that of an expert observer that stands apart objectively outside the family system (Anderson, 2003; Gergen, 1999).
These various shifts in positioning have contributed towards the development of a more collaborative and transparent therapy relationship in which the therapist is a far more active and present participator in the client’s story. In this way, therapists are seen as contributors in the meaning making of clients in therapy (Anderson, 2005). The therapist’s self is dialogical and relational, linguistically and socially created (Anderson, 2005, p. 499).

As such, the therapist is always translating, and interpretation is a dialogical process, and takes place within a recursive relationship. What is familiar to the client gets talked about in unfamiliar ways that create new meaning for them. In this novel way, the realisation of what is unfamiliar leads to further curiosity and anticipation (Anderson, 2007a). In this way, the family therapist became an essential part of the therapeutic change process by co-constructing meaning with their families (Cheon & Murphy, 2009; Rhodes et al., 2011).

2.7.3 The Importance of Relationship and the Therapeutic Alliance

Various studies have indicated that the quality and type of therapeutic relationship is an important variable for therapy to have a positive outcome and to succeed (Beck & Jones, 1973; Blow, Sprenkle, & Davis, 2007; Carr, 2005). From a dialogical perspective, “it makes a bigger difference who the therapist is than which method is used” (Rønnestad & Skovholt, 2002, p. 3). Flaskas (1997) approves this by accentuating that the alliance between the family therapist and clients is a dynamic process along the therapeutic trajectory. These endorsements are further evidence of the postmodern shift previously highlighted and the position that the accountability on the part of the family therapist seems to be an active and intentional aspect of the therapeutic alliance.

Yet, in spite of the acknowledgment of the dominant role that the therapist plays in therapeutic outcomes, partial information seems to be present on the individual characteristics of family therapists that might enhance therapeutic engagement and connection (Holmes, 2006; Lebow, 2006).
A dialogical emotional component to family therapy was introduced by Rober (1999) who also stressed that family therapists should reflect on their inner dialogue in their work with families, and in this way, be able to select which aspects of themselves as both professionals and people to take with them into the therapy room.

2.8 Our Inner conversations

In recent years, inspired by Bakhtin’s concept of the dialogical self as a polyphony of inner voices, some family therapists have described the therapist’s self as an inner dialogue (e.g., Andersen, 1995; Anderson, 1997; Anderson & Goolishian, 1988; Penn & Frankfurt, 1994; Rober, 1999, 2002). Anderson and Goolishian (1989) stated that the therapist maintains a dialogical conversation with himself or herself, which is the starting point of his or her questions.

Rober, (2002) felt that this part of the therapist’s skill is crucial for the positive humanising aspects of therapy to take place, and so his concept also fits snugly as a natural extension of humanistic positioning and serves as a way to further develop this discussion related to dialogical understanding. The dialogical conversation has been called the therapist’s inner conversation (Rober, 2002). Several authors suggested that the concept of the therapist’s inner conversation shows promise in addressing the mutuality and shared activity of a therapeutic relationship in the complexity of family therapy practice (e.g. Andersen, 1995; Flaskas, 2005; Lowe, 2004; Rober, 1999, 2002, 2005a).

The concept of the therapist’s “inner conversation” refers to the private dialogues therapists have with themselves while practicing and talking with family members/clients during sessions. Perhaps, the therapeutic beauty of this idea lies more in the fact that as opposed to its premise being based on a guiding principle about what therapists should or should not do in therapy, or how they should ideally position themselves during the work, the therapist’s inner conversation is a means by which the therapist can lean upon their own process to further reflect, think and talk about their positioning and experiencing in the session, thus giving access to implicit or unspoken aspects of the therapist’s self in practice (Rober, 1999, 2002, 2005a).
Rober (2002) speaks of the experiencing self and the professional self. Viewed thusly, the therapist’s inner conversation can be described as a dialogue between the experiencing self and the professional self. The therapist creates a reflective space. This may occur after the session, for instance, or during the session in which the therapist can take some mental distance (or outsideness, as Bakhtin would call it). In this space, the therapist reflects on his or her experiences, on his or her position in the conversation, and on what he or she will do next. Here, the therapist’s responsibility is of central importance because this is where the therapeutic and ethical choices are made.

According to Rober (2010), acting out impulsively in therapy or losing contact with clients may be our way of protecting ourselves: keeping strangeness at bay and avoiding being really aware of the confusing things we are feeling. That is why carefully reflecting on one’s own experiencing and positioning during the session is vital (Rober 2010). It is however not always possible to find the time and space to really reflect on these things candidly during the session. Taking time after the session to think over what happened, or even better, to talk with colleagues or with a supervisor about the session, is no luxury, but rather a necessity.

Seen in this way, connection in the life of a therapist is multi-faceted and occurs on many different levels. A supervisory safe haven can also be a place where striking moments of clarity can occur through transparent conversations which are then taken back into the therapy room by the therapist in the service of meeting and making other connections with the client/s.

As a concluding comment, Hoffman (2002) explores the therapist’s experiencing also as a tool when she writes about ‘travelling empathy’, or ‘tempathy’ for short. Tempathy refers to a kind of transpersonal communication that is often reflected in the images, ideas or considerations that can pop up in therapists’ inner conversations while they are talking to family members (Hoffman, 2002).
2.9 An Emotional Focus

Aware also of the need to include an epistemological focus in this review, from a personal and professional perspective, I became acutely aware of the role of emotions in our therapeutic undertakings, and in the area of connection, namely due to my personal struggles in training and in sessions, where my natural tendency was to be persuaded to yield to my core emotional reactions and responses with clients.

2.9.1 The Dialogical Use of Emotions in Therapy

Emotions are complex whole-person responses that involve behavioral dimensions as diverse as muscular activity, subjective experience, attention and thinking, and not infrequently (but not necessarily) have a rapid onset outside awareness (Lang, 1970; 1988; Leventhal, 1984; Mauss, Levenson, McCarter, Wilhelm & Gross, 2005).

Emotions are also concerned with our most essential needs around connecting with others as social beings. From an evolutionary perspective, they rapidly alert us to situations important to our wellbeing. They also prepare and guide us in these important situations to take action towards meeting our needs. From a dialogical perspective, they can be said to better inform both the therapist and client/s alike, to better identify, experience, and respond to, their emotional responses. In terms of forging stronger connections with our families, the use of our emotional responses as a lens for filtering information may sometimes ameliorate this process, but at times it can also contaminate this process, because as a lens our emotional responses may distort and even unduly filter out relevant information. It can be difficult for the therapist to detect what the feeling means in the moment and how it is related to the flow of interactions in sessions. Therapeutically, instead of concentrating the analysis on the emotion’s content, the therapist can find out what the emotion is a response to and what it means in context. This amounts to a focus on what exactly is being felt or, in other words, on what the therapist is sensing and not on the sensation in itself.
2.9.2 Experiencing our own feelings as connective tools

Elkaïm (1997), proposes a systemic view of the therapist’s feelings, stating that the first tool of the therapist is the therapist’s self. So for Elkaïm the therapist should not try to avoid experiencing, but rather ‘use it as the heart of the therapy’ (Elkaïm, 1997, p. 170). Elkaïm stresses the importance of the context in which the therapist’s feelings arise. According to him, what therapists experience during sessions not only comes from their personal history, but is also amplified and maintained by the dialogical context.

2.9.3 Emotionally focused therapy

Emotion-focused therapy (EFT), also known as process experiential therapy (PE) (Elliott, Watson, Goldman, & Greenberg, 2004; Johnson & Greenberg, 1988; Greenberg & Watson, 2006; Greenberg, Rice, & Elliott, 1993) is an empirically supported humanistic treatment that views emotions as centrally important in the experience of self, in both adaptive and maladaptive functioning, and in therapeutic change. EFT theory incorporates a number of humanistic phenomenological principals (Rogers, 1951, 1957; Perls, Hefferline, & Goodman, 1951) concerning human nature.

2.9.4 Change process from an EFT perspective.

The therapist is fully present, unconditionally accepting, empathic, and genuine (Rogers, 1957; Greenberg & Watson, 2006). These qualities provide real human contact that reduces clients’ feelings of isolation, increases the experience of being accepted and enhances interpersonal safety. This creates the optimal environment for focused attention to turn within, and eliminates the client’s need to attend to interpersonal processes occurring between them and the therapist (Rice, 1974). Added to this, therapists are in constant empathic attunement with clients’ affect and meaning. At all times, the therapist tries to make psychological contact with and convey a genuine understanding of the client’s internal experience (Rogers, 1951, 1957).
2.10 The Embodiment Process.

Lipchik (2002), emphasised the centrality of the client-therapist relationship, and the importance of building collaboration through the sensitive attendance of the “emotional climate” of the session. On a practical clinical level, theorists such as Virginia Satir were responsible for generously endowing us with shrewd and honest practice based observations when she reflected upon and later testified: ‘What am I doing? I am accessing the right brain when I ask somebody how they feel and when I help them to connect with parts of their body’ (Satir, 1985, in Simon, 1992, p. 170).

2.10.1 Dialogue and dialogical interaction as a lived experience.

Dialogue and dialogical interaction is not just about the exchanging of words and utterances, but something that involves the systemic interaction of whole persons. Lannamann (1998) emphasizes, it is in the relational act of speaking and reacting to each other through our mutual embodiment processes that our words are shaped, interpreted and understood. From a dialogical aspect, this is very interesting as the therapist can offer to client/s their perspective from how they are experiencing them from the confines of their own body and their relational embodiment process.

As post-Freudian therapists, we are aware only too well that conscious thought is made up of non-conscious parts such as unconscious emotional components and mental processing and automatic motor responses. Normally, these functions are presumed to arise as a result of brain activity that encompasses part of the body. Consequentially, systemic therapies were thus burdened with these abstract conceptualisations of the therapeutic embodiment process, and although the idea of body and embodiment remained important, from a theoretical standpoint, systemic therapists were also often guilty of inadvertently excluding the significance of the role of this sensory based focus when they theorized. Advances in brain science help us describe and model in detail these non-conscious neural processes (Lombardi, 2008).

Contemporary developmental psychologists have shown that in the development of the structure of human brain and body, dialogue is a fundamental formative process.
originating in the first months of life. Vygotsky’s idea that the mind originates in relationship resonates with the ideas of Bra’ten (1988, 1992, 1997a, 1997b), Stern (1974), Siegel (1999), and Trevarthen (1979a, 1979b, 1990, 1992), who describes the infant as engaging in a dialogical relationship with others from the earliest postnatal moment. Trevarthen’s (1979a) careful observations of parents and infants demonstrate that the original human experience of dialogue emerges in the first few weeks of life, as parent and child engage in an exquisite dance of mutual emotional attunement by means of facial expression, hand gestures, and tones of vocalization. This is truly a dialogue; the child’s actions influence the emotional states of the adult, and the adult, by engaging, stimulating, and soothing, influences the emotional states of the child. Simultaneously, our personal constructs about our development of “ourselves” is the notion of the self as being something that is given to us and something alien to our being that somehow through a disembodiment process somewhat lives within the confines of our physical body.

From a constructionist perspective, the mind/body dualism however is now also based on the belief that the role of the individual self stands aside its interaction with one’s environment. In infancy, we start to develop a sense of ourselves through the bodily interaction with our care givers as Daniel Stern’s research has demonstrated (Stern, 1995). The self thus closely situates the relationship between these two dualities as existing side by side to each other through our bodily dealings with our environments.

In conversation and figures of speech we are seeing the emergence of the creation of disembodied dialogues (see Bertrando, 2000) and the trend has been to emphasize words and narration, obscuring the relevance of body interaction. The possible adverse effects of this position have been criticized on good grounds by John Lannamann: ‘When ideas become radically separated from embodied practices, the sensuous activities of everyday life tend to be subordinated to disembodied abstract differences’ (Lannamann, 1998, p. 400).
2.11 Conducive Connective Moments in Therapy – A moment in Time.

In therapeutic terms, moments of connection refer to brief, transient moments or instances where client and therapist alike experience feelings of time having almost stood still and they are two very vulnerable people alone yet united in their humanity journeying through life and connected in their boundlessness (Rober, 2008). Other emotions reportedly connected to these experiences are those of extreme joy, marvel, gratitude and serenity coupled with a sense of meaningfulness and clarity as to how to go forward, and thus they may be considered as transformational moments as they may be instrumental to the change process and overall therapeutic outcome. As therapists’ we are privileged to share these moments in time with clients.

From a theoretical standpoint, these moments of connection may offer us a way as therapists to resituate and reposition our frameworks within the more traditional and perhaps formal structured methods (Lowe, 2005) and offer us much needed alternative ways of meeting with our families and clients. If we consider the more structured avenues of traditional therapeutic frameworks and practice, it is easy to see how taking a dialogical stance with clients offers us as therapists a new way forward for something different yet equally accommodating and flexible.

2.11.1 Emotional Exchanges as a Therapeutic Panacea

Emotions, like any other action, are immediately shared when they happen. When we perceive joy or pain in another person, we put into activity the very same cortical areas that are activated when we feel those emotions (Rizzolatti and Sinigaglia, 2006). There is little or no difference, according to these findings, between feeling, showing that feeling, and perceiving that same feeling. We may say, therefore, that emotions are one of the main means of communicating essential information about each other. If we accept this, then from a dialogical perspective, all our exchanges are emotional exchanges of some sort or another.
2.11.2 Sticky Moments as Connective Glue.

Several authors in the family therapy field have written about the challenge for therapists in dealing with difficult emotions such as shame (Kavner and McNab, 20), despair (Flaskas et al., 2007), anger (Rober, 1999), fear (Doan, 1998) and so on. These emotions can be hard to manage for the new therapist, and they can become a barrier to the development of a good therapeutic alliance. Perhaps because often such emotions can paralyse therapists, as they raise doubts in therapists’ minds about their professionalism and therapeutic skills. Furthermore, they can lead to alliance ruptures (Safran et al., 2002). In addition, they may push therapists into dialogical positions that lead to impasses that are not helpful or even destructive for the therapeutic process (Flaskas, 2005; Rober, 1999).

From a dialogical perspective, moments of shame can also be experienced as universally humanising connective experiences and this can be bonding in terms of helping the client to feel understood. Perhaps because, if a therapist can communicate to the client that they have felt their pain this may be experienced as validating by the client. Relationally speaking, it is often when a client feels deeply ashamed or insecure about some aspect of his/her experience, that they are also humbled, and at that moment clients may be brought back into secure and non-threatening therapeutic contact by the presence of a non-rejecting other. In these highly intense moments of humility empathic affirmation or validation by the therapist of the universally normalising aspects of negative emotions may help the client to shift their experience to one of more hope.

These therapeutic polarities deal with the complexity of the therapists’ experiencing and their exposure to helplessness during sessions. Seen in this way, some of the therapists’ uncertain clinical experiences in therapy can become useful in promoting a collaborative therapeutic dialogue and moments of deeply felt connection. In this way, barriers may be thought of as potential therapeutic connective tools.

The flip side to taking this position is that when a therapist knowingly chooses to ignore or avoid certain contact with unwanted feelings, or rejects them, he or she unwittingly may be colluding with the negativity in the room, and may be ignoring
vital clues that could imply that something important is going on in the therapy process. In this regard, Pope, Sonne and Greene (2006) recommend systematic efforts to detect and explore therapist feelings related to taboos and issues that are hard to admit and deal with.

On the other hand, acknowledging experiences of this nature is sometimes hard, as it also means moving from an awareness of the experience, to learning how to bear them and tolerate them. According to Frosh (2004), dealing with the unsaid and the unsayable is frightening for therapists as clients appear as others (Larner, 2004) or as strangers (Kristeva, 1991), while at the same time they demand something from the therapist. This can evoke feelings of impotence and vulnerability in the therapist. It may also stir up the issue of feeling like an impostor (Clance and Imes, 1978; Sightler, and Wilson, 2001), as it can give rise to therapists’ secret fear that they are not worthy of their position as therapists: ‘When clients say, ‘help me, cure me, reach me,’’ what on earth do they want? And why, especially, do they want it from me?’ (Frosh, 2004, p. 60).

This might imply that these ideas could be connected to the views of authors valuing the therapist’s experiences in the session, and exploring the importance for the therapist of holding open a space for reflection (e.g. Elkaim, 1997; Flaskas, 2005; Larner, 1996, 2004). Furthermore, they fit in with a dialogical approach to family therapy (Rober, 2005b; Seikkula and Olson, 2003) in which the therapist’s task may be described as listening to the stories the clients tell us, and making room for alternatives that have not been aired before. Ultimately, the therapist is emotionally affected by this encounter (Rober, 2012). We cannot always know what these moments are and perhaps we shouldn’t ever necessarily ‘know’. Perhaps, their true beauty and potential for connection lies in their creation and the experiencing of that creation.

A moment in time is often a sharing of vulnerability where the “protective hesitations” spoken of by Rober (2016 verbatim) are let down and made visible. We connect and then that moment becomes the past. It’s fleeting in its charm, it captivates us, and then is elusive once more. Perhaps because of the nature of these transient moments, it cannot be revisited with any integrity, but it can be
remembered in the spirit of its creation, as a moment suspended in time laden with hope and potential. Rober (2016), immortalised similar thoughts by stating that “hope is imagining the future sometimes long before the family can and then taking them there” (verbatim).

2.12 Conclusion

The theories presented in this chapter are based on research carried out overseas. Given that no such studies in the area are available in Malta, I needed to familiarise myself with other existing literature in order to gain a better understanding of the topic being researched. This literature review supported me to contour the research question of this enquiry. It also helped me identify and address a research gap and narrow down the research topic. Moreover, looking through the existing research helped me take into consideration other aspects such as social constructs of therapy. Keeping in mind all the different aspects of therapy processes, I chose to focus my study on the lived experience of the participants, within the Maltese context.
Chapter Three
Chapter 3: Methodology

3.1 Introduction

This chapter describes the methodological approach used in this study. In it the motivations for adopting a qualitative approach will be outlined. As will the rationale for choosing IPA as the research methodology. The recruitment criteria that was used whilst selecting the participants and the interviewing process will follow. In the last segment of this chapter, issues pertaining to the trustworthiness of this study will be addressed. The chapter will conclude by addressing the ethical implications involved in such an undertaking and priority will be given to this and to the researcher’s self-reflexivity.

3.2 Research Questions

The study was designed to explore the following research question: “As systemic therapists, what are the effects of spontaneous transformational moments”? By way of exploring this further the following questions were also considered:

1. How are these moments merged in our relational conversations with clients?
2. How do these processes ameliorate change?

An overall aim in this research is to gain a better understanding of how connection in the relational context affects the process of change in therapy.

3.3 A Qualitative Approach

The qualitative approach towards research in psychotherapy is being given more credence today, and is becoming more recognised as a scientific approach to research. It is argued that qualitative research is an effective way of conducting research since the complex, qualitative nature of human experience provides a thorough understanding of the subject matter of the research (Howitt & Cramer, 2006). Moreover, qualitative studies aim to capture the subjective experience of the
individual whilst embracing the complexities and diversities in the same experiences (Holloway & Todres, 2003). Furthermore, qualitative research concerns itself with the meaning people give to their experiences and provides detailed and rich accounts of the data collected (Braun & Clarke, 2014). It also looks for assumptions about the specific understanding by individuals or groups of people within an ascribed situation (Creswell, 2007).

Another important factor in qualitative research is that it is not limited by existing knowledge on the area being explored (Braun & Clarke, 2014). This is pertinent since this study is designed to shed light on a research gap related to an area of research that is considered elusive in family therapy research, being that of connection and change in the therapeutic relationship. Thus, the flexible nature of qualitative research might support the emergence of rich accounts that could provide unexpected insights on the subject being explored (Braun & Clarke, 2014).

Moreover, the voices of the participants are privileged through the outcomes, which include “contextualized verbatim quotes from participants” (Dallos & Vetere, 2005, p. 50). In opting for a qualitative research design it can be explored how the participants’ experience shaped their inner world and their interpretation thereof (Cresswell, 2009). Also, as a research approach, qualitative research incorporates aspects of social constructionism, constructivism, and hermeneutics (Gehart, Ratliff & Lyle, 2001). As researcher, the aim is to use postmodern informed methodology to socially construct the meaning of the participants in their connective moments with clients in therapy.

Another position being given privilege to in this piece of research is a mind full respectfulness of the importance of situating theory in qualitative research methodologies. In doing so, I hope to show the connective relationship between theory and practice and this will also be highlighted upon as means of expanding and elucidating upon constructionist argument and understanding. This is namely to support the importance of including one’s researcher belief system in the work.

One of the oldest definitions on scientific theory was given by Hempel (1952, p. 36) who compared theory with “a complex spatial network” whereby “system” and “observation” are the floating device, while “rules of interpretation” control and
guide them. Homans (1952, p. 812) believes that essentially no theory exists unless there is a clear “explanation” on the “properties” and “propositions” which clarify their relations and finally forming a “deductive system.

In addition, Burr (2015) was concerned with deductive theory and assumes that propositions “explain why certain things occur”; afterwards deducing them. She then concludes that these propositions are examined and tested as science has a purpose; elimination of “invalid propositions” and increasing the number of “useful and valid” propositions (Burr, 2015, p. 3). In contrast, Silver (1983) claims that once a formal definition is offered for theory, its true beauty, emotional significance and importance in everyday life will be lost. This is an important factor to keep in mind considering the often indefinable nature of the subject area under scrutiny.

3.4 Methods of verification

IPA was chosen over other qualitative and phenomenological approaches to generate exploratory experiences as perceived by the participants who are working with clients. The aim of this research was not to generate a theoretical-level account of this phenomenon as found in grounded theory (Smith, Flowers & Larkin, 2009), rather, to generate experience from the participants which is interpreted by the researcher. This research is embedded in theoretical and philosophical underpinnings of IPA.

As outlined above, the study aims to identify emerging themes and meanings that the participants have given to their experiences. Various methods of research exist within the qualitative paradigm, thus, before choosing the method for this research, I explored the different possible approaches that could have been chosen, amongst these grounded theory (GT) and thematic analysis (TA). The central focus of qualitative research is to enrich our understanding of the enquiry at hand and whilst commonalities can be found across the mentioned methodologies, distinct features in their assumptions and implications are also present.
When deciding on which research design to adopt for a study, researchers need to reflect on a number of questions. Braun and Clarke (2014) state that it is imperative to ask questions related to what the researcher aims to discover about the phenomena being researched as well as the kind of data collection that is required. After taking into consideration my research question, the aim of the study, and sample size, it was decided that IPA was the most suited approach for this enquiry. IPA is also particularly suitable when the topic is under researched (Smith & Osborn, 2008).

In order to explain my reasons for choosing IPA as the paradigm for this study, I will first give a very brief description of grounded theory and thematic analysis; describing reasons why these were not the chosen designs.

Grounded Theory is mainly concerned with the social processes that occur in human interactions and the generation of a theory thereof, particularly when the area is under-researched (Braun & Clarke, 2014). Moreover, Biggerstaff (2012) argues that Grounded Theory is not ideal when the aim of a study is to capture complex lived experiences of the participants.

On the other hand, Thematic Analysis is somewhat similar to IPA; However, it mainly focuses on the identified themes and patterns of the experience and the exploration of an issue or idea (Attride-Stirling, 2001). Unlike IPA it is not recommended when the focus of the study is to address people’s experiences in depth.

3.5 Research Design

The design will be as follows:

- IPA study

- 5 in-depth semi-structured interviews with female systemically trained psychotherapists about their experiences of relational connection with clients

- Analysis through IPA
3.5.1 Interpretive Phenomenological Analysis

After examining the different qualitative research methodologies available, I observed that the research questions outlined would be best addressed by adopting a phenomenological research method. My decision was rooted in the knowledge that “phenomenological research is a strategy of inquiry in which the researcher identifies the essence of human experiences about a phenomenon as described by participants” (Creswell, 2009, p. 13).

This study aims to provide a contribution in the existing literature gap, specifically in the area of systemic practice. The research question was considered first and consequently the ways in which it could be explored thereby tailoring the methodology to the research question (Kasket, 2012), and finally choosing IPA.

After these considerations, Interpretive Phenomenological Analysis (IPA) (Smith, 2004) was identified as the most adequate methodology for this study. The choice was mainly due to IPA’s overarching objective to explore the lived experiences and the meanings individuals assign to them (Smith et al.,2009), which is as has been described in line with the aim of this study.

The IPA researcher approaches their study with two aims in mind. The first being an ability to understand the world of their participants, and the second aim is to develop a more obvious interpretative analysis which positions the initial description within and in relation to the wider societal and cultural and perhaps even theoretical contexts (Larkin et al, 2006).

As such, this type of research is deemed systemic and thus offers a second order account which aims to provide an in depth relational understanding of the participants’ sense making activities (Smith and Osborn, 2003). From a systemic perspective, any study of human behaviour and development must include within its perimeters the importance of the subjectivizing influences of language, culture,
ideology, beliefs, assumptions and relationship. From this viewpoint, it is acknowledged how the human individual is seen to be embedded in the reality and world it inhabits. Reality in this sense is thought to mean, “what it thought about things in general” (see Bohm, 1980) rather than how things really are when thought is removed. IPA also fits well within a systemic and constructionist framework as it also acknowledges the importance of the researchers’ self-reflexivity and relationship between parts.

An IPA study was also deemed well suited as it commonly involves a highly intensive and detailed analysis of the accounts of a relatively small amount of research participants.

### 3.5.2 Theoretical and philosophical underpinnings of IPA

The philosophical underpinnings of the study will now be discussed. Information related to the selection process of the participants will be outlined. Also included will be the credibility, reliability and trustworthiness strategies used, to ensure and safeguard the integrity and rigour of the research.

IPA stands on three major philosophical positions: phenomenology, hermeneutics and idiography.

#### 3.5.3 Phenomenology

Phenomenology concerns itself with what constitutes our lived experiences, thus giving a richer source for examining and understanding the lived world (Smith et al., 2009). Experience is examined in a way that it occurs to the participants of the study, as suggested by Smith et al., (2009). The participant is embedded in “a world of objects, relationships, language and culture, projects, and concerns” (Smith et al., 2009, p21) as each perspective and meaning is elicited through interpretation. Phenomenological research is therefore concerned with first person perceptions and accounts of life experiences and looks for an understanding of meaning and essence.
of an individual’s experience (Langdridge, 2004). Moreover, it is concerned with capturing the participants’ experiences by delving deeper into their meaning making process (Smith, Flowers, & Larkin, 2009).

3.5.4 Hermeneutics

Another theoretical underpinning of IPA is hermeneutics, which concerns itself with interpretation and how this interpretation could be influenced by the different contexts of both the author and the interpreter (Smith, Flowers, & Larkin, 2009). Freeman (2011) states that “hermeneutic valence” (p. 543) is offered through dialogue. She claims that the understanding of meaning is directly attached to particular events from which meaning is created and constructed. This ontological position postulates that people make meaning of their experiences by being part of the experience rather than from looking at the experience. Thus, these viewpoints fit well within the frameworks of social constructionism and dialogic positioning.

Hermeneutics asks questions about interpretation and whether it is possible to interpret meaning in its original form. This position supported me to keep in mind the wider picture when collecting data. Furthermore, it prompted me to orient myself with the notion of double hermeneutics. Heidegger (as cited in Smith, Flowers, & Larkin, 2009) spoke of double hermeneutics, which concerns itself with the role of the interpreter, claiming that when carrying out a study, a researcher needs to reflect on how one’s own perceptions can influence the meaning made from the data collected. He claimed that it is of vital importance that researchers need to be aware of how their interpretations of the world, constructed through feelings, beliefs, thoughts, and one’s own experiences, may interfere. Smith, Flowers, and Larkin (2009) claim that for a study to be truly phenomenological in nature, the researcher needs to also acknowledge their own ideas and biases. They state that researchers need to reflect on how to detach themselves’ from the activity by “bracketing” their preconceived ideas about the topic under study, even though it is acknowledged that this can happen only partially.
Interpretation involves interpreting the text that was produced by the participants which in turn involves a dynamic relationship between the part and the whole (Smith et al., 2009). The double hermeneutics involves understanding part of the participant’s experience, including the participant’s personal beliefs, background, training and personal philosophy. One word is understood in the context of a sentence, which is in turn understood in the context of the complete text. This reflects the process IPA in that it is dynamic and circular rather than linear (Smith et al., 2009).

3.5.5 Idiographics.

IPA research is generally pitched at the idiographic level. This term has traditionally been associated with the study of “individual” persons though it originally served a wider function, namely to distinguish the study of specifics from the study of “things in general” or nomothetics (see Lamiell, 1998, Windelband, 1994/1998). Idiography concerns itself with the specific experiences of individuals as opposed to making generalised assumptions about bigger populations (Dallos & Vetere, 2005). This does not mean that generalisations cannot be made, but rather they are to be made with caution (Smith & Osborn, 2008). However, IPA is more committed to the detail of the experience, through deep analysis of the interviews and the meaning and is thus deemed idiographic in nature and employ through its use of small sample sizes and detailed analysis of each and every case.

Analysis in IPA concerns taking a more in-depth look at the part. In fact, idiography is concerned with the particular and the detail as well as understanding how particular phenomena are understood by particular people in a particular context (Smith et al., 2009). In this study, the small sample size allows for a detailed analysis of the part, analysis of how each participant perceived the detailed lived experience of engaging with clients during moments of therapeutic connection. Each different and unique experience analysed allows for particular and detailed generalisations to be made (Smith et al., 2009). The participants chosen for the study were asked to explore their perceived experience in a form of narrative. Indeed, this
phenomenological analysis focuses on “exploring experience in its own terms” (Smith et al., 2009, P.1).

3.5.6 Critique of IPA

Often, IPA is misunderstood in that it is thought to offer only a “simply descriptive” methodology (Smith, 1996). The same author goes on to say that perhaps, a better way of looking at this type of research stance would be to consider it as being more “flexible rather than less detailed”. Some other proponents have summarised that “IPA can be easy to do badly, and difficult to do well” (Larkin, Watts, Clifton, 2006). This may be tied up with the fact that it can seem enough to just collect the data and represent the voices of the research participants only.

3.6 Participants.

The research questions need to be significant to the participants in order to provide the researcher with rich and pertinent data (Dallos & Vetere, 2005; Smith & Eatough, 2006; Smith et al., 2009). This usually requires the use of a purposive sampling technique for the selection of participants (Smith & Eatough, 2006). A purposive sampling technique was enacted in order to obtain the five participants of this study. This technique was chosen as it involves the selection of participants that can provide “information rich” (Patton, 2002, p. 230) experiences that were pertinent to the main theme being explored. The choice of the sample size was based on Smith et al. (2009) recommendations, that a sample size between five and seven participants is thought to be sufficient for meaningful patterns to emerge but at the same time limit the risk that the researcher becomes overwhelmed with the amount of information gathered.

The sample chosen for this study involved five Maltese practicing family therapists, and so information gathered is located within a context and, thus, capturing the experience within the Maltese context was deemed systemically valuable to the study. King and Horrocks (2010) state that data which takes into account the cultural and historical meaning, is more rich and complete. This will give more
understanding to the experience of the participants as is the aim of qualitative research (Willig, 2001).

Another salient point worth mentioning is that initially I was not clear as to whether I wanted the study to be gender-specific or whether I was interested to look at the experiences of both genders. After much deliberation and owing to limitations of time, word count, and availability of systemically qualified psychotherapists of both genders, I decided to limit the study to focus on the experiences of female psychotherapists when they experienced relational connection with clients.

As the aim of the enquiry was to generate a deeper understanding of the emerging themes and patterns of the experiences of systemic psychotherapists when experiencing connection in the relational context, a purposeful sample was utilized (Patton, 2002). A homogeneous group was deemed as the most appropriate sample as the enquiry was very specific in nature, Smith et al. (2009) point out that “IPA researchers usually try to find a fairly homogeneous sample for who the research question will be meaningful” (p. 49). Also, when choosing a homogeneous population, one reduces the degree of the external factors which may interfere with the research (Dallos & Vetere, 2005).

3.7 Recruitment Process

The chosen topic being one in a therapeutic context meant that it was familiar to me, so initially, I felt that finding participants would be relatively easy. However, as I went along with this process I became aware of certain restrictions that I was encountering, which were namely the fact that not all Maltese “systemically” trained family therapists had Masters Degrees. This was because some locally trained family therapists had qualified through other professional routes and not exclusively through being in possession of a recognised Master’s Degree.

Also, bearing in mind that due to the geographical size of Malta being a small island, the local population of family therapists is rather small and many of the professionals were personally or professionally known to me. Due to the existence of
these dual relationships conducting research that involves a personal relationship with the participants might be challenging especially because of the blurred boundaries that might arise (Gunasekara, 2007). Another compounding factor related to this was the fact that as a professional and trainee family therapist, I already share an insider identity with some of the participants.

This could pose the risk that whilst carrying out the interviews with known colleagues or peers, the information disclosed might stem from the ease emanating from the pre-existing familiarity of relationships. This could create tension between what data to use and which to omit, which in turn might pose a risk as valuable insights might be lost (McDermid, Peters, Jackson, & Daly, 2014).

3.8 Selection Criteria

All participants needed to be in full possession of a Master’s degree in systemic psychotherapy and practising therapy in Malta as the study was situated in the Maltese context. Systemically trained psychotherapists working in both public and private practice were contacted via email and a letter outlining the aims of this research was sent out to them. This email gave details with regards to this study (Appendix A). Once participants accepted to participate they were asked to read and confirm their participation by signing a consent form (Appendix B).

With regard to ethical considerations, each participant was made aware of the relevant therapeutic facilities available to them should they feel that they needed to process their interview responses and reflections thus ensuring that any emotional distress was kept to a minimal (Corbin & Morse, 2003).

In terms of anonymity, all participants in the study were assigned pseudonyms and a representation of their main characteristics.
3.9 Data Collection

This study utilised in-depth semi-structured interviews for data collection as recommended by Smith et al. (2009). In-depth interviews invite participants to share detailed first-hand accounts of their experiences (Smith et al., 2009). For this purpose, face-to-face interviews were chosen as the preferred method for data collection.

In this way, as researcher I was able to meet the participants and attempt to gain an in-depth understanding into their world (Rubin & Rubin, 1995). This is important because, the IPA researcher is more concerned with how their participants experience or understand any given phenomena as opposed to the exact nature of what is being researched by them. For example, connection in the generic sense is replaced by how the participant experiences connection in their own idiosyncratic way. Often in phenomenological analysis this is referred to as their “life world”.

3.9.1 Semi-structured interviews and interview schedule.

It is considered that for rich data to emerge, the participants need to be given an opportunity to freely express their experiences and reflections (Smith et al., 2009). Therefore, a semi-structured format was followed throughout the interviews. This gave me the ability to balance between asking prepared questions on the selected topic, whilst also simultaneously attempt to explore in-depth the participants’ experiences (Smith & Osborn, 2003).

An interview schedule (see Appendix C) was prepared prior to commencing the interviews. The format prepared was not intended to be definitive but acted as a foundation to engage the participant in a co-created and interactive dialogue (Biggerstaff & Thomspn, 2008; Smith & Osborn, 2008). This was composed of a list of open-ended questions based on the literature that I have reviewed and my personal reflections related to the link between connection, personal reflections and clinical practice. In their nature, open-ended questions allow participants to give
their own interpretation of the questions asked and, thus, they had the possibility to answer according to their experiences and feelings thereof (Braun & Clarke, 2014).

As the process took place during the interviews, I adapted some of the questions according to the participant’s replies and modified these according to any attention-grabbing themes that came up through questions and prompts (Dallos & Vetere, 2005; Smith et al., 2009). There were instances when participants answered the questions whilst narrating their experience and this was welcomed by me as the researcher. In this way, the schedule proved to be helpful as it supported me to keep the research questions in mind and ask similar questions to the participants. However, it also gave opportunity for distinctive aspects of participants’ experience to emerge. This type of interview allows for digression, where the interviewer can probe to gain a deeper understanding or for perception checking (Braun & Clarke, 2014).

3.9.2 Pilot study.

A pilot interview was conducted as a means to identify any possible changes that needed to occur prior to the actual interviews. This process supported me to establish any practical problems which may have hindered the research process. Moreover, the pilot interview provided me with the opportunity to reflect on my position as the interviewer, and also highlighted areas in which I needed to improve, so as to help the participants tell their story without interfering with the phenomenological process of the interviews (Sampson, 2004). Pilot studies have the potential to further strengthen the study, as they can elicit areas of improvement prior to the commencement of the interviews (Kezar, 2000).

I was very aware that I was quite nervous during the pilot interview and this led to me asking the participant awkward stiff sounding questions initially. Asking the participant too many questions at one go, can make it at times difficult for the participant to reply in-depth (Smith et al., 2009). The above reflections and feedback from the participant allowed me to be more aware of my own positioning and how best to prompt participants in future interviews (Biggerstaff & Thomspn, 2008).
During the interview process I also found myself confused about whether my role was that of a therapist or a researcher, and I noticed that I was inclined to naturally assume a therapeutic stance. However, overall, when reflecting on the experience of the pilot interview, I found that my therapeutic experience was helpful in general. In this regard, Sammut Scerri, Abela, and Vetere (2012) state that as practitioners, we have therapeutic skills which can support us as researchers when conducting interviews. However, it is also important for us to remain aware that we do not use these skills to elicit information which was not consented to (Kvale, 2007). Nevertheless, the data collected from the pilot interview was detailed enough that it could be considered for inclusion as part of the main study.

3.9.3 Conducting the interviews.

Once the identified participants agreed to take part in the study, an invitation to schedule a time and date for the interview to take place was sent via email. Bearing in mind that all the participants were practising family therapists, as researcher I was accommodating and scheduled interviews according to their needs. This flexibility might have supported the participants in that it may have reduced their stress levels around participation due to their probably already heavy work schedules that normally go hand in hand with the work commitments of busy psychotherapists. In this way, I also thought that this may have built some rapport prior to the interviews taking place.

Participants were informed that the interview schedule will be sent by email prior to the actual interview taking place. In this way, they could peruse the questions, and this was done to help the participants to have a feel for the study subject area in advance which would hopefully allow them an opportunity to think ahead about the research questions. Our exchange of email messages prior to the interview helped in initiating my connection with the participant (Deakin & Wakefield, 2014).

During the interviews, the first few minutes were spent trying to develop trust and ease with the participant and this seemed to take place through initial small talk or by exchanging clinical experiences. Before initiating the interview, the participants
were also offered the opportunity to clarify or query any information in relation to the study or myself as a researcher.

Towards the end of the interview, I proceeded by debriefing the participants. I informed them that the interview was coming to a close and invited them to add any further comments they might have crossed their mind. As way of showing my gratitude for their participation in this research, at the end, the participants were thanked for their time and generosity.

Throughout this interview process, in order to help me reflect on how my own position could influence the data analysis, I kept a reflective diary, where I wrote down my thoughts and feelings when listening to the audio interviews, or reading the transcripts of these. The reflective diary, supported me to better understand how I positioned myself in relation to the data collected and how this could have affected the interpretation of the same data (Smith, Flowers, & Larkin, 2009).

3.10 Data Analysis

The data was analysed using IPA, whereby the interviews were audio recorded and listened to and then transcribed and read repeatedly, so as to become more familiar with the data. This process helped me to enter into the world of the participants, as suggested by Reid, Flowers, and Larkin (2005).

Although IPA is considered to be flexible in nature, it also outlines a number of steps to support the researcher to identify central themes within the data collected (Storey, 2007). IPA also views the analysis as “an iterative process of fluid description and engagement with the transcript” (Smith et al., 2009, p. 81).

3.10.1 Steps Carried out during Analysis of the Transcripts.

Following transcription of each interview, the first step was to repeatedly read and re-read the written text. This process was also complemented by simultaneously listening to the audio recording. This allowed me to become
immersed in the data, which ensured that the participant was my main focus (Smith et al., 2009). The audio recordings were listened to more than once so as to be able to pick any changes in tone of voice, silences and any other information that would make the data richer. With each transcript I took notes of anything that struck me or drew my attention in some particular way, and these included the experience of the participants, how they made sense of their own experience, as well as their thoughts (Smith, Flowers, & Larkin, 2009).

I then listed these emerging reactions to the text in the right hand margin of the transcript. Smith et al. (2009) recommend that the researcher remains free to comment on anything he or she deems striking within the data being read. However, to remain loyal to the interpretative nature of IPA, notes included: “descriptive comments” that outlined the participant’s lived experience, “linguistic comments” that focused on the language used by participants to narrate their experience; and “abstract or conceptual comments” that included my own interpretation of the participant’s experience (Braun & Clarke, 2014, p. 214).

The next stage involved returning to transcript and using the comments that had previously been noted to elicit emergent themes. In doing so, I attempted to be mindful of keywords or phrases in the text that contained “enough particularity to be grounded and enough abstraction to be conceptual” (Smith et al., 2009, p. 92). The aim was to come up with brief and concise statements that included all the salient comments related to a piece of transcript (Smith et al., 2009). For interest, during this process the interview is not seen as a whole but is divided into parts, which then come together again as a whole in the write-up produced at the end of the analysis (Smith et al., 2009). The themes outlined reflect the participant’s reflections together with the researcher’s interpretation. Once elicited the themes were written on the left hand side of the transcript.

The final step in the process was an attempt to provide order and structure to the analysed data by finding connections amongst the elicited themes (Storey, 2007). This was carried out by looking for similarities between themes and clustering them together to develop what is known as super-ordinate categories (Smith et al., 2009). Following this step, I developed a table (Table 2) which displays the ‘master’ list of
superordinate categories and the sub-themes which make them up (Smith & Eatough, 2007). The table includes evidence from the interview transcript by selecting quotations that capture the essence of the participant’s reflections with regards to the specific themes (Biggerstaff & Thomspop, 2008).

As a concluding comment, every interview was analysed individually before moving on to the next interview where the above four stages were repeated. This process took place with all the five interviews. The list of themes that emerged from each interview were grouped together into one combined list. This list was compiled by building on the master list of superordinate themes and sub-themes, which made up the first interview. The list of themes together with their associated quotations, were used to form the accounts that are presented in the next chapter.

3.11 Credibility and Trustworthiness of the Study

Various elements were considered before deciding which measures of trustworthiness would best fit with the enquiry. I reflected on the chosen theoretical frameworks and epistemological position that were guiding this study and attempted to opt for measures that were congruent in this regard. Moreover, I kept in mind throughout the three underpinnings and tenets that guide all phenomenological studies, which attempt to be as faithful as possible to the experiences of the participants (Holloway & Todres, 2003).

As a foundation, sensitivity to context was given priority in order to ensure credibility and trustworthiness in this study (Yardley, 2008). The primary focus was on the specific lived experiences of the purposeful sample of the participants chosen (Smith et al., 2009). The research supported my pledge towards upholding an interactive process during the data collection stage. One way that this was enacted was through adopting a respectful stance to ameliorate the participants’ security during the interviews. During the data analysis the same respect for context was also taken into consideration for example, discussions and suggestions on the different aspects involved in the data collection and the analysis of the data with my supervisor helped support me in this process (Creswell, 2009).
In this study, I also used three reflexivity interviews which contributed towards the trustworthiness of the study. The first reflexivity interview was held before the pilot interview took place, the second was held after another two interviews and the process of transcribing had commenced, and the last reflexivity interview was held when all the interviews had been transcribed and at the point in which the analysis started to take place. Dallos and Vetere (2005) state that this process validates relevance and creates coherence of the analysed data and makes for a more credible final report which truly represents the story of the participants.

During the research interviews, I became more aware and clear about my personal and professional biases, and this allowed me to take a closer look at how my own story and experiences could impact the whole process, such as the constant dance between my role as a researcher and that of a practitioner (Creswell, 2007). Moreover, these interviews served as an external check throughout the whole research process, in which I could note my positioning and track if it changed through the process (Creswell, 2007).

### 3.12 Ethical Considerations

As best I could, throughout the study, I was committed to being transparent and thorough in the steps undertaken in the process. To highlight transparency, I have included a sample of an interview transcript, which outlines the process by indicating original notes, and emerging themes (see Appendix D).

I was also fully mindful of providing ethical practice throughout the whole research process by giving priority to the safety and anonymity of participants (Creswell, 2009).

The recruitment of participants and data collection was initiated only after all the steps in the research process were granted by the relevant ethics board.
3.12.1 Informed consent.

A detailed information sheet (see Appendix A) provided information about the aim of the study and the necessary data collection process. This was given to each participant prior to the interview. Emphasis was made on the matters relating to confidentiality and voluntary participation. Furthermore, participants were reminded that they are able to withdraw their participation from the study at any point during the research process. Upon their confirmation of all of this, the consent form (see Appendix B) was signed and the interview commenced.

3.12.2 Confidentiality.

As the methodology used requires the use of excerpts from the transcriptions (Smith, 2004), this could pose risks to confidentiality and participants were informed that any sensitive information that might lead to their identification would be changed within all printed documentation. This was because, in the context of such a small island as Malta, anonymity remained at the forefront of my mind. Participants were also assured that transcripts and recordings would be kept in a safe place and will be destroyed upon graduation accordingly.

3.13 Potential distress.

It was noted that because the recruited participants were experienced family therapists, who are familiar with self-reflexivity and processing, the risk of personal distress due to participation was thought to be minimal. However, to mitigate any distress that participants might feel, they were informed that they could refrain from replying at any point.

3.14 Epistemological Reflexivity.

As can be seen, in IPA methodology, the researcher role plays an integral part in interpretation of findings. Therefore, in this section, I will outline how my
position might have influenced the research process. The intersubjective relationship between the researcher and the data collected is acknowledged throughout the process (Smith et al., 2009). Biggerstaff and Thompson (2008) highlight that “rather than attempt the impossible task of seeking to diminish the researcher’s role, IPA makes the positive step of acknowledging and exploring her role” (p. 221).

Literature suggests that researchers have a clear objective and awareness of their research and its possible outcomes (Wiling, 2001). So it is pertinent also to explore the relationship between the philosophical underpinnings of this research vis à vis my personal reflexivity.

A constructionist epistemology informed my stance whilst carrying out the interpretation of the lived experiences shared by the participants. This stance claims “knowledge of how things are, is a product of how we come to understand it” (Braun & Clarke, 2014, p. 30). The interaction between the researcher and the participant is a central characteristic to constructionism (Ponterotto, 2005). Through this stance, I felt that the meaning of the lived experiences shared by the participants emerged as I actively interacted with them during the data collection phase. I also embraced social constructionism as a stance in my research because theoretically, it was “composed” of a wide collection of perspectives, and as Gergen (1999, 2001a) pointed out, it is not empirical methods, such as experiments, that are compatible with social constructionism but the universalistic truth claims that usually accompany them.

As a trainee family therapist and researcher, who has struggled with connection in both roles, I reflected on why I had specifically chosen to focus on such an “intimate” topic, despite these personal difficulties as a research area. In particular, these thoughts became crystallised for me when in understanding my role as a researcher, I found myself also understanding how my choice of research was indeed rooted in these personal paradigms about connection, relationship and change. In this regard, Doherty (1999) comments that the role of the postmodern researcher is also to make verbal the values and assumptions underlying the work, and he asserts that postmodernism has exposed the fact that what we choose to identify with is very much connected to our choice of research (Doherty, 1999).
I think it pertinent to assert these personal belief systems because my own self constructs about connection strongly influence my researcher role through my understanding of the phenomena being examined. I would hope that through leaning on my role as a postmodern constructionist researcher, and through the flexibility provided by this particular stance I would be able to reveal more about the relationship between my own personal beliefs and connection as a researcher and clinician. In this way I was supported to make the necessary shift from my original epistemological place of fear and hesitation around my researcher and therapeutic role, to one where I began to view the person-researcher-clinician role as a helpful relationship that could exist side by side, and indeed needs to be inter-connected.

I also thought a lot about how my own experiences with connection might have influenced my interaction and interpretation of the experiences shared by the participants around this subject area. This became particularly apparent to me when for example during the interviews I had particular questions about connection that seemed to intrigue me more. Throughout the research process, I engaged in being very aware of what belonged to me. This was so that I could remain open but not biased and allow the participants’ experience to remain at the centre (Smith et al., 2009).

Also, I hail from a different culture to the participants and so I reflected also on the impact this would have on both our interpretive frames during the data collection and analysis process. Much (as cited in Smith et al., 2009) claims that “cultures are, effectively, frameworks for meaning-making” (p. 194). I reflected whether this could have contributed to a lack of understanding on my behalf which could have influenced meaning.

The other epistemological stance guiding this study was a dialogical approach. This approach contends that mutual respect on all levels is essential to the process of therapy. It was interesting to note upon reflection that I could apply these principles even to my own research process in the supervisory relationship. My tutor and myself seemed to have formed a dialogical understanding of our own, where he provided the conditions of safety necessary for me to believe in my own competence as a researcher, and where he respected my needs and my pace. His emotional
attunement to those needs provided a sense of containment for me. I did not feel pressured or hounded to perform and because of this I was less anxious. He seemed to know just when to connect with me and when to let go. I felt supported in this journey as a researcher. It was clear that on some level a parallel process was taking place which echoed the core elements of dialogical understanding.

Further evidence of the importance of being familiar with my own preferred ways of being and process, was when I noted that during my interview analysis process as I listened to the audio, I seemed to relate to information more when I listened to the participants’ voices, tones and cadence etc., rather than just viewing words in black and white on paper. From this reflection, I realised that my own particular preferred way of connecting with people seems to be through my sensory perceptions and through my responses to emotional cues in the audio. Listening for me as a researcher seems to take place in this primitive and human way.

Throughout this study, I strived to remain self-reflexive, and because of this stance I think that I have become much closer to connection as a theme in my life in general, both personally and professionally. Carrying out this study and having to be constantly in touch with my own process in this way, whilst being open to the support and guidance of my supervisor and peers during this endeavour, has helped support me to reach out to others when I need to. This has shown me that connection is not something to be avoided or fearful of and that this is what I now need to model to my families in practice.

3.15 Conclusion

This chapter outlined the philosophical and theoretical rationale for the methodology adopted for this enquiry. Information regarding the recruitment process, the interview schedule and the data collection were discussed. Positioning and self-reflexivity were also discussed by the researcher. The main findings will be presented in the following chapter.
Chapter Four
Chapter 4. Findings

4.1 Introduction.

This chapter will give a detailed presentation of the findings of this research. An Interpretive Phenomenological Analysis (IPA) of the transcripts yielded seven superordinate themes which captured the experiences of the participants of this study. Exploration of the superordinate themes and their subordinate themes will form the basis of this chapter. Each theme will be illustrated to highlight the experiences of systemic psychotherapists during moments of connection with their clients. Verbatim extracts will be used to encapsulate the experience. Missing material from the verbatim quotes will be indicated by three dots – (...). Some background information about the participants will follow. All identifying information has been changed or removed and pseudonyms were used for the same purpose.

The family therapists recruited for this study kindly shared unique and interesting aspects of their past and present therapeutic experiences and clinical practice. In their contributions they shared how they perceive these experiences to be linked to their practice in family therapy. This chapter will therefore present the different accounts generously given by the participants.

4.2 Background Information about Participants

This research was based on the experience of five women who are practicing systemic psychotherapists locally (see Table 1). Their ages ranged between 35 and 55 years of age. All the women were born and bred on the Maltese Islands, although some had spent time overseas during their training. Four of them were married with children and one was separated and childless.
Table 1: Demographics of Participants

<table>
<thead>
<tr>
<th>Name (pseudonym)</th>
<th>Gender</th>
<th>Age</th>
<th>Marital status</th>
<th>Years in Profession</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elenora</td>
<td>Female</td>
<td>40–45</td>
<td>Married</td>
<td>10</td>
</tr>
<tr>
<td>Claudia</td>
<td>Female</td>
<td>35–40</td>
<td>Married</td>
<td>5</td>
</tr>
<tr>
<td>Cara</td>
<td>Female</td>
<td>40–45</td>
<td>Married</td>
<td>15</td>
</tr>
<tr>
<td>Rula</td>
<td>Female</td>
<td>40–45</td>
<td>Separated</td>
<td>15</td>
</tr>
<tr>
<td>Ilaria</td>
<td>Female</td>
<td>50–55</td>
<td>Married</td>
<td>20</td>
</tr>
</tbody>
</table>

Table 2: Superordinate and Subordinate Themes

<table>
<thead>
<tr>
<th>Superordinate themes</th>
<th>Subordinate themes</th>
</tr>
</thead>
<tbody>
<tr>
<td>4.3 Connection as a</td>
<td>4.3.1 Use of self of the therapist seen as a vital component of therapy</td>
</tr>
<tr>
<td>firstly human</td>
<td>4.3.2 Therapeutic relationship: cultivating connection</td>
</tr>
<tr>
<td>endeavour</td>
<td>4.3.3 Cultural thinking around helping others</td>
</tr>
<tr>
<td></td>
<td>4.3.4 Sense of marvel about humanity</td>
</tr>
<tr>
<td></td>
<td>4.3.5 Personal and professional life experiences of therapist viewed as creating</td>
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<td></td>
<td>therapeutic connection.</td>
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<tr>
<td></td>
<td>4.3.6 Therapists’ learning through the sharing of clients’ humility and disclosures</td>
</tr>
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<td></td>
<td>4.3.7 Therapists provide a safe and secure base</td>
</tr>
<tr>
<td>4.4 Therapists have</td>
<td>4.4.1 Feelings of intuitive compulsion towards entering into the therapeutic</td>
</tr>
<tr>
<td>internal calling to</td>
<td>profession</td>
</tr>
<tr>
<td>become therapists</td>
<td>4.4.2 Therapists’ own life stories viewed as a driving factor towards becoming</td>
</tr>
<tr>
<td></td>
<td>therapists</td>
</tr>
<tr>
<td></td>
<td>4.4.3 Therapists’ willing to work on themselves</td>
</tr>
<tr>
<td></td>
<td>4.4.4 Therapists defined as sensitive towards the pain of others</td>
</tr>
<tr>
<td>4.5 Attunement to the</td>
<td>4.5.1 Heightened level of physical awareness for both therapists and clients</td>
</tr>
<tr>
<td>embodiment process</td>
<td></td>
</tr>
<tr>
<td>4.5.2 Training process of therapist serves as a guiding force in facilitating therapeutic journey for clients</td>
<td></td>
</tr>
<tr>
<td>4.5.3 Experiential aspects of clients positioning therapists in being accommodating towards clients’ needs</td>
<td></td>
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<tr>
<td>4.5.4 Energy shifts during the session seen as indicative to therapeutic connection: positive or negative</td>
<td></td>
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<tr>
<td>4.5.5 An emotional saturation process that gives way to deep learning and connection</td>
<td></td>
</tr>
</tbody>
</table>

| 4.6 Is connection felt or seen?: Therapists’ perspective | 4.6.1 Notion of connection: fluid and enigmatic as a felt sensation |
| 4.6.2 Connection as the main source of therapeutic healing |
| 4.6.3 Interdependency between therapeutic interventions and connection |
| 4.6.4 Lack of contact with clients seen as indicative of lack of connection |

| 4.7 Resonance with life scripts | 4.7.1 Therapists’ own life scripts seen as determinate in the preferred theoretical choices |
| 4.7.2 Theoretical underpinnings provide a sense of security |

| 4.8 Meaning making: The search for “truth” | 4.8.1 Therapists’ providing a safe base from which client can be supported to search for their personal truth through connection and open conversation |
| 4.8.2 Constructionist perspective encourages the development of a mutual sense of meaning making |

| 4.9 Seeing the past: to let it go | 4.9.1 Allowing one’s own past pain to act as a key to unlocking how therapists reach the pain of clients |
| 4.9.2 Letting go of one’s own beliefs and judgements seen as a vital element in facilitating connection with clients |
| 4.9.3 “I listen more and I connect” |
| 4.9.4 Notion of redundant therapist: stepping away to allow clients to sustain themselves |
4.3 Connection as a firstly human endeavor

This master theme identified the personal understanding of the participants of this study. Several of the research participants spoke of how they viewed connection as being primarily a relational connection which occurs as a consequence of being human. Connection in therapy and outside of it was thought of as an involuntary connective process resulting from shared needs and experiences as humans. The respondents also identified our first relationships in life as our first connective and relational experiences.

4.3.1 Use of self of the therapist seen as a vital component of therapy

All the participants acknowledged this important aspect of their work when they described how they utilise their use of self therapeutically through various methods and as a result of different influences or experiences in their lives. The participants indicated that they perceived their personal experiences to be linked to their professional journey and therapeutic work. They explained that the connections between their personal influences and their professional practice in family therapy were fused, and indeed this position was a preferred way of being and stance for most of the respondents. From this it could be seen that the two roles of the private and the professional are intertwined and not necessarily distinct from each other.

In the following sub-theme, the respondents explained how they took their past and current experiences and learnings with them through their use of self in to the therapy room and their meetings with families. What came across from this particular sub-theme was that apart from being trained in a particular therapeutic modality that enhances therapeutic skills, family therapists made use of their personal experiences whilst attempting to understand families.

Some of the participants emphasized that personal and private experiences are an integral part of who they are, and so they should be included in their therapeutic encounters with families as a method of connecting with clients. In this regard, one respondent said she consciously did this through the normalising of life’s universal difficulties and tribulations. This was reported by Claudia who said she tried to
engage with clients by going down to their level by showing her vulnerability, through their shared experiences as humans,

“oh I know what it means I've got children myself and last time they did this; so in a way I'm using a bit myself to help also building up that relationship but I do tend to focus consciously sometimes to build that relational connection”. (Claudia)

One respondent Cara captured this involuntary connective element in therapy when she said,

“I find myself caring for them, thinking about them so it is a connection between one human being to another and that's how I see you know my work to be” …. “I keep them in mind” (Cara)

4.3.2 Therapeutic relationship: cultivating connection

In this subordinate theme, the idea of connection being something that is worked towards then arrived at through a conscious refinement process was also expressed by several of the respondents. The main finding from these reflections and remarks was that connecting with families takes time and effort and needs to be thought of in relational terms. It is not a finishing line but more of a journey where the therapist accompanies the family to this place of understanding and encounter.

Claudia in particular used the term, “the cultivation of connection” to describe this process in therapy. Whilst another respondent (Rula) summed it up as follows,

“I think it's the basis of our work I mean relational connection is what therapy is based up really so unless you can develop relational connection you cannot actually have a therapy you know”. (Rula)

In this way Rula seems to describe connection as the pivotal foundation to the engagement process with the client/s which develops as a result of the willingness of the therapist involved to create and develop this through safety.
4.3.3 Cultural thinking around helping others

In this subordinate theme, there were valuable insights provided by various participants which highlighted how as therapists they were also influenced by their own cultural beliefs and norms about caring for others and connection. This accentuates the impact of culture on the lived experience, and several of the respondents narrated their views of how their own cultural expectations influenced their perceptions in therapy and their roles within these contexts. These findings showcase the particular importance of being mindful of situating the participants in the various contexts they inhabit and how as professionals they are embedded in these throughout their therapeutic process.

A cultural component to connection in the local context was illuminated beautifully by Cara when she spoke of how Maltese people tend to be generally helpful and kind hearted towards others, and how this translates for her in her therapeutic role with families,

“in Maltese we have a saying like 'irridulhom il-ġid' (We want the best for them) ... “so it's like you know you want them to do well in life”. (Cara)

Cara also mentioned how holding a non-judgemental attitude around cultural beliefs helped with experiencing connective moments with clients during moments of difference.

“for example experiences of being different in Maltese society for example so maybe the client would be talking about you know her process of coming out as a homosexual or a bisexual and I then would talk about some experiences of difference in our society and the struggles you know, so that kind of thing”. (Cara)

Claudia also introduced a cultural focus to her work when she shared how her training and life overseas years before had positioned her differently within the local Maltese context in which she practiced now. She felt that this time away from Maltese cultural and social norms had opened up a space within her that had made her more tolerant and less judgemental with families because living away from Malta’s insularity had she felt broadened her horizons clinically, and she hypothesised that these factors aided her in her ability to connect with various client
populations and groups. She further elaborated on her own travel life lessons when she said,

“The flexibility, for example something that I've learnt from living abroad and something that I feel I've got quite a lot with me and I think it's important”. (Claudia)

4.3.4 Sense of marvel about humanity

This sub theme indicated that some of the participants felt that in being family therapists they were privileged to be able to reflect on how they themselves position themselves in the world through their learnings and optimism about life from clients. Often this clinical awareness and knowledge would be then carried into their own personal lives and their relationships outside of therapy and practice. This provided some of the respondents with a sense of relief and refuge from the harsh realities of daily life, because they felt it offered them more choices and alternatives both in therapy and with their own loved ones, and this composure helped them to feel more at ease with clients in the work.

For example, one of the participants outlined how their therapeutic work and life had been enriched and changed by the awareness from their clinical families that suffering can be recovered from and it can even offer a space for growth and development. This tended to imbue their own life with optimism, and this in turn acted as a therapeutic promoter for them to be able to remain hopeful even in the darkest of circumstances therapeutically. Cara emphasized this by her use of the phrase that with clients she had,

“a sense of marvel about humanity”. (Cara)

From a dialogical perspective, these shared instances between therapist and client during moments of mutual respect seem to have left the respondent feeling elevated and changed from inside. Cara further elucidated this by adding,

“there are times when I marvelled at their resilience or they taught me a lot and I guess having this connection with another human being through therapy is a way of giving meaning to my life”.
4.3.5 Personal and professional life experiences of therapist viewed as creating therapeutic connection.

Following on from the previous sub theme, in this theme, several respondents highlighted how being a family therapist had been a positive and enriching life experience, which they felt facilitated them in connecting with others. Something that seemed to be a vital component to this was the conscious joining together of the therapist’s personal and professional life experiences to guide them in their work. This mainly came about through the participants’ eagerness to learn from their clinical conversations with families and they saw this openness as being conducive to connection in therapy.

Some of the participants viewed their therapeutic experiences with families as a synthesis of existential human suffering culminating in growth for the therapist. This was seen as coming about through the acceptance of life’s reality and the human bonding process that accompanied these shared experiences. From this, participants described how even the most difficult or painful of life situations could be normalised therapeutically through their ability as therapists to provide the client/s with a sense that things would be ok no matter the level of suffering.

Linked to this, other respondents also felt that it was far better for the clients to look upon them during such difficult moments in this mutually bonding susceptible way rather than to assume that as therapists their own personal lives were perfect or pristine. This may have been because a therapist considered as untouchable could also perhaps be perceived as unreachable too by clients.

“You are alone in the struggle, I can't go you know but at least we're kind of in it, it's not, you're not crazy, it's part of humanity, it's part of human suffering”. (Cara).

As therapists, the respondents felt that the therapeutic strategic use of proximity with their families and positioning themselves equally with the suffering and despair helped the family to remain grounded. As professionals the participants felt that in this shared way they could revitalise their client/s sapped energy in these intense situations through adopting a resilience based focus.
“I suppose in the sense I marvel at the resilience of the human spirit. I think it's that it gives life a certain, this is something a bit of a cliché, it's not a sparkle but I guess you know some kind of like an energy”. (Cara)

4.3.6 Therapists’ learning through the sharing of clients’ humility and disclosures

As has been previously expressed, during the interviews, the majority of the respondents emphasized that their therapeutic practice and growth as family therapists was enhanced by the personal learnings given to them by clients, both about themselves and their work, and during their therapeutic encounters with families. These very precious candid connective moments were especially apparent for the participants when clients offered themselves and their own exposure to the therapist through their personal disclosures. The respondents reported that witnessing such honesty was very humbling for them and it became an integral part of their personal growth and professional development.

The participants also indicated that they welcomed and indeed held self-disclosure experiences during the therapeutic encounter in high regard because they felt that it was a time when their families were at one with them, and in the safety of this therapeutic embrace they experienced this time of coming together in this way to be both helpful and meaningful to them in their work.

This subordinate theme may imply that as therapists the participants felt that they were honoured to have these universal humilities bestowed upon them by their client/s generosity and authenticity. This may have been a behaviour that was firstly modelled to the participants by the client/s, and then incorporated by them in their work. This then helped the respondents to support their respective families by in turn modelling this same truthfulness and validity in their practice and interventions. Cara gave an example of this when she offered how she makes herself available in the work.

“I extend my hand, my training, my experiences and I say 'look I've gone through this and I can really witness and I can really maybe you know in sharing some of what I went through, a little, maybe you can understand that you're not alone in this”. (Cara)
Participants also felt that it was therapeutically better to adopt such a collaborative stance and for clients to perceive them as humans in this exposed fragile way rather than be thought of as the expert. This may have been because such a demarcation could have been perceived as distancing to the client/s and may have also been a hindrance to relational connectivity.

In this very real way, it was deemed far better to be part of life’s universal misfortunes by the respondents than to be aloof from these from a therapeutic perspective. This type of connectivity in the work was seen as being the connective glue that kept the participants bound to their families.

“I hold myself to have learnt about life and relationships through all these different people. I guess there was a time when this connection with the people was experienced by myself as burdensome, now I guess I am hold more of a spiritual existential position I suppose but it came through time and maybe through me getting older, I don't know I mean it's something it's a work in progress you know”. (Cara)

From this excerpt it can be seen how exposure to client work over the years by the respondent and her own physical maturation process personally and professionally helped her to keep a healthy distance between what belonged to her and what pertained to the client/s. Looked at in this way, connection at this level seems to be more of a synthesis of her whole way of being rather than merely an engagement process mechanically carried out.

Another participant’s account also resonated with this stance,

“the stance that I would want to stay in and I try to keep to you know a humble position of you know remaining curious with what clients bring, whatever they bring because in a way they teach me”. (Ilaria)

4.3.7 Therapists provide a safe and secure base

In this subordinate theme, the therapist was seen as offering a secure base to the client/s, through conveying to their families that they were available, and this was thought of in terms of pre-empting and building upon the relational safety and
trust necessary for therapeutic work to commence and therapeutic connection to take place.

Claudia felt that qualities in the therapist like providing a “supportive friendly person and atmosphere” (Claudia) where approachable characteristics in the therapist were also seen as being pre-requisites to supporting the client/s to trust the therapist further in order to elicit connection. Claudia also expressed these sentiments around the creation of safety on a human level before commencing therapeutic work,

“So yes, it is definitely important in the beginning and I think before there is some level of relational trust I think it's hard to start any proper work”. (Claudia)

Another respondent, Ilaria felt that it was also very important to make the effort for this human connection to take place prior to any clinical undertakings.

“I invest in putting in the time and the space to make sure that at some point there is this you know the sense of feeling connected to the client relationally”.

…“I cannot imagine a therapist personally who will not invest in creating the safe, secure base and that connection with the client”. (Ilaria)

4.4 Therapists have internal calling to become therapists

Another superordinate theme that presented itself was the idea of therapists having intuitive compulsions to become therapists based on their own need for connection which they identified as being present early on in life. These notions seemed to come as a result of the participants’ difficult relationships in their own development and the losses that were incurred as a result. The awareness of their own primitive need and hunger for relationship and connection seems to have fuelled their quest to connect with others in the greater context of life.
4.4.1 Feelings of intuitive compulsion towards entering into the therapeutic profession

Several of the participants shared that early on in their lives they had felt a need to help or connect with others and this was what they felt was one of the reasons responsible for them gravitating towards their careers as psychotherapists.

One participant Elenora underlined this when she stated

“I certainly do experience connection with my clients because I find it the work I do is very meaningful to me, I chose to do it, I feel like I had this call to do this type of work since I was a kid”. (Elenora)

These sentiments were further outlined by Elenora who also stated that

“many of us in the work are drawn to this because of our life stories and these are what propelled us to become therapists”. (Elenora)

Another respondent, Rula felt that being a therapist and connecting with people happened on an intuitive intrinsic level,

“I don't think it's something you can learn about it but I think it has to be in you”. (Rula)

Rula also felt that relational people become therapists because of their propensity for connection, and were born with an “innate curiosity or ability to connect”

...“I think we have people who go into psychology, who go into therapy, who go into this kind of field usually have a propensity towards connectedness, towards believing in relationships, towards wanting to connect with people on different levels and that is why we are in this profession”. (Rula).

4.4.2 Therapists’ own life stories viewed as a driving factor towards becoming therapists

In this subordinate finding, several participants reported that their own life stories had also acted as a type of propellant or inspiration for them entering into the profession. Respondents brought forward detailed experiences from their personal lives that they felt were influential or pertinent factors to their choice of profession and eventual career in becoming family therapists.
Participants seemed to offer experiences in their own relationships where they felt that their own connections were in some way compromised. This seemed to instigate in them a felt need to provide others with a different more positive story to their own emotional experience. A shared underlying thread to the respondents’ experiences seems to have been related to absences of connection or validation in their respective relationships with significant others growing up.

Elenora spoke at large about this,

“as I was growing up I always felt that genuineness and authenticity and really being there with the person and seeing them so that they can feel seen and validated was something that I missed, and because I missed it I did not take it for granted, and I always remember saying to myself, and this is what actually brought me in this work in the first place, I’d like to be able to learn how to experience this and share it with other people in simpler words I remember myself saying ‘I want to help children to feel understood because this is what I need to feel’”. (Elenora)

Cara also contributed to this theme when she said,

“I think we are who we are because of our relationships whether it's past relationships, present relationships, it's like we are not an island”

4.4.3 Therapists’ willing to work on themselves

In this subtheme respondents described how they perceived therapists as being people who were willing to invest in themselves throughout their lives. There was a shared understanding between participants that in doing so they helped cultivate an ability to nurture and connect with clients in therapy because of the sustenance and wellbeing their own self-care gave to them as people. This seems to indicate a felt need to give a conscious priority to caring for oneself first in order to be able to connect with others.

Connected to these thoughts, most of the participants stated that therapists who invest in relational connection in therapy, also value their connections and relationships outside of therapy in their personal and public relationships and deeds.

Cara spoke about the idea of therapy as also being likened to a personal life care that needs sustenance to flourish and can sucked out from the therapist if not attended to
in terms of self-nurturance. A taking care of one’s own life in order to be able to connect in a wholesome healthy manner with clients was seen as a must by Cara.

... “you have to know where you start and where you finish and then you can be in a relationship”. (Cara)

4.4.4 Therapists defined as sensitive towards the pain of others

Most of the respondents characterized therapists as being hyper sensitive to the pain of others. This was elaborated upon by various respondents in different ways. The participants also shared examples of therapeutic instances which rendered them to the realities and other less positive aspects of practicing family therapy. Respondents described therapeutic encounters where they were left feeling overwhelmed or burnt out by what they encountered in their work. This sometimes led to them developing feelings of therapeutic incompetence or comparing themselves less favourably to their colleagues etc.

“I sometimes wonder do they do the therapy in a different way than I do for example because usually when I see five people in an evening I'm exhausted, I don't usually I'm not ready for the next day to see the same you know”. (Cara)

Pain as a therapeutic phenomenon, was seen to be both a universally bonding feature in therapy, and at times a burden, which was carried for the most part by the therapist as a result of being exposed to the client/s raw emotions and having to maintain clinical boundaries too. This clinical load was experienced both physically and emotionally by some participants. Cara reported,

“Sometimes I had clients where I really felt I accompanied them in their sadness and I felt sad myself, I felt burdened, I felt heavy”

Ilaria described how pain was experienced by her as both connecting and isolating.

“usually it's moments where there is deep pain, where there is this you know it's clear the pain can be felt, it's very raw and obviously I'm very touched in those moments when the clients share something which is especially painful for them”.
For Rula, suffering through pain was different and she described that she experienced this as exquisite in its propensity for connection. During these episodes with clients she felt supported as a therapist to view difficult moments as sources of resource. She felt that this was possible because of the deliberate positioning she assumed vis a vis these polarised states. She also felt that taking a philosophical view about life’s painful realities and hardships in this way connected her. She felt that because she chose to view pain in this way she was better equipped in her formulations of questions. This was mainly because she felt that her way of looking at pain united her with the client’s suffering and helped her to elicit resources from them. For Rula pain was a connective gel in therapy.

“I could really feel connected with that loss and with the pain”. (Rula)

4.5 Attunement to the embodiment process

All the participants in one way or another shared the common view that their awareness to the relational connection process with client/s was enhanced and indeed somewhat guided by their own embodiment and emotional responses during the work. An overarching theme was that therapists need to be able to regulate and self soothe their own affective responses in order to engage relationally and cognitively with their client/s.

4.5.1 Heightened level of physical and sensory awareness for both therapists and clients

In this subordinate theme some participants shared how during moments of intensity and connection with families they often experienced these moments in an embodied way through their various senses.

Elenora described how she was acutely aware of physiological changes in her body whenever she encountered connective moments in therapy, and that these particular instances indicated to her a time for checking with the client/s about what was occurring between them. It was a time when she felt the need to touch base with the client/s so that she would be mindful of whether her somatic response belonged to
them and her reaction was to their situation, or whether this emotional trigger in her was more to do with unfinished business of her own which was a somatic expression of her resonance with something in the system.

“I even feel it like on a physical level. So sometimes I get the chills or sometimes I start to get emotional and I would want to acknowledge that and to try and understand what actually happened in our conversation that touched us that way”. (Elenora)

Other participants also reported heightened physical awareness and physiological changes in their own bodies and/or positioning. Cara, explained how she felt zapped or drained of energy and depleted emotionally after particularly heavy sessions or multiple back to back sessions,

“for me it's very emotionally engaging, very emotionally intense. For me therapy is not just cognitive, it involves a lot of emotions, it involves me my whole person hood kind of thing so I feel very tired, I feel like you know some kind of energy has been sucked out of me you know”. (Cara)

Whilst others commented on changes in energy levels or atmospheric conditions in the therapy room, Claudia mentioned how during instances of connection,

“the atmosphere in the room is different”. (Claudia)

This statement indicates that when connection takes place its tangible for both therapist and clients and that from this connection between them another element is felt.

4.5.2 Training process of therapist serves as a guiding force in facilitating therapeutic journey for clients

Another subordinate theme that surfaced was how the undergoing of systemic training also served as a valuable space for guidance and treasured insights for the respondents in their current clinical practice. In training it was remembered by one particular participant Elenora how connections could be elicited within her by the observation team’s reflections during sessions. Elenora felt that she carried forward these learnings to her current work with families. Those observatory reflections from long ago had stayed with her and she reflected on how they had
helped her to be cognizant of her own emotional blind spots with clients when she had her own emotional triggers with those families identified to her by the team during sessions.

These learnings from her peers in the past helped facilitate and support her to hold and contain the emotional process of the clients in her present day practice. This training legacy was in her opinion a valuable inheritance. She felt that the emotional safety the team had instilled in her was something that she too wanted to offer to her clients in the present day.

“I remember them helping me hold this experience and reflect on the impact of this conversation on me and when I went back in the room I was supported by this understanding.” (Elenora)

4.5.3 Experiential aspects of clients positioning therapists in being accommodating towards clients’ needs

This theme will attempt to give meaning to the accounts narrated by several of the research participants regarding how their own positioning in the work was facilitated or shifted by courtesy of feedback from clients about what they experienced as helpful by the therapist.

Two of the participants Rula and Elenora, spoke of how they were often made aware of connectivity by something that they had missed in the work and that had been brought to their attention by the client/s. This awareness from the client/s then helped the therapist/participant to adapt their own positioning to accommodate the needs of the client/s.

Rula described how sometimes clients would surprise her or catch her off guard when they would come to another session and give her feedback about what had helped them to shift. This may not have been something that as the therapist she had thought of as meaningful or significant yet nevertheless the client had found her intervention transformational.
“They could experience something which you have not seen or foretold so they would come and tell you ‘you know what? Last time you really got me there' and I'd say OK, I wasn't like thinking about that but that made sense to him or her and it happened”. (Rula)

Elenora also offered similar insights when she also described,

“I think, open conversation about what we are experiencing is very important to kind of avoid any misunderstandings because I know that, even I read somewhere in a particular study, what therapists might have experienced as meaningful sessions; 'Ah like this time I think it was a good session'; it's not necessarily obvious that it was experienced in the same way for the clients. Sometimes when I ask the families, like what was meaningful to them, they do come up with episodes that I might not have necessarily thought that they were that meaningful unless I had asked about them”. (Elenora)

These two excerpts both seem to highlight how from a social constructionist and dialogical position, healing therapeutic conversations can occur in the most mundane or practical ways as long as there is an openness for this type of dialogue to be received and welcomed.

Ina different manner, Claudia was keen to stress how she felt that a lot of her guidance in the work came about as a result of her trying to envisage or experience what her client/s are feeling or needing through her own experiential experience of what it would feel like for her to be them in her own embodiment process.

“I consciously would be seeking to develop, to focus on the relational aspect, how do I think the client is feeling at the moment, what do I need to do to help the client feel more at ease in the session”. (Claudia)

4.5.4 An emotional saturation process.

Several participants seemed to indicate through their text that deeply experienced connective moments were instances of total saturation both mentally, physically and emotionally for the therapist. In this regard, Ilaria interestingly used the term the “felt connection” to distinguish the position of the therapist from the client/s during these moments of connection. She elaborated on these thoughts by
trying to describe what it feels like for her as a therapist during these moments by saying,

“I would think that there is both a similarity and a difference, the similarity in connection the felt connection may be similar to both I would say.....“I would say a difference would come in when the therapist needs to be cognizant of what they are doing in the connection. There needs to be a particular awareness to process what is going on which is then something that the client doesn't need to do”. (Ilaria)

“They feel close to the therapist, they feel connected with the therapist but they don't need to do that work of processing the meaning of the connection for example or taking a meta position about what is going on in the connection”. (Ilaria)

For Ilaria the felt connection is greater for the therapist because of the cognition necessary to also process and keep boundaries, etc., with client/s. Ilaria described this process as a form of responsibility which was also another type of strain that was placed solely on the shoulders of the therapist during these connective moments adding to this saturation process.

This sub-theme could also indicate that connection seems to be influenced by how the therapist in taking a meta-position to their own thinking coupled with attending to their own emotional reactions and responses along with those of the client/s during therapy, tended to burden them somewhat, and this may not allow them the same freedom as the client/s who exempt from such a cognitive encumbrance were able to relate on a more practical level to what constituted connection for them.

4.6 Is connection felt or seen?: Therapists’ perspective

This superordinate theme namely came about because of an interesting pause on the audio tapes when several of the participants were asked to pinpoint a connective moment with client/s in therapy. This could imply that therapeutic connection may not be experienced by therapists as a quantifiable phenomenon. Trying to find words to articulate what takes place for the therapist during these instances seemed difficult for most of the respondents. Perhaps this could indicate that as an occurrence deeply felt connection takes place on a sensory or intuitive
level and trying to give verbal expression to this takes away some of its mystique and charm.

4.6.1 Notion of connection: as fluid and enigmatic experienced as a felt sensation.

This subordinate theme deals with the notion of connectivity being thought of as fluid like and unfathomable, a not knowing of how it has occurred but a recognition of when it does, by the therapist. Cara offered these reflections to try to capture the elusive nature of what’s going on inside of her during her connective experiences with clients,

“I know who I am, and like I’ve described to you, but I don’t know how I’m coming through to them, I’m not sure, so I think I would need to ask them”.
(Cara)

She also added,

“I come, I connect, then let go and then I come and connect and let go”.
(Cara)

From her reflections it would seem that felt connection is a time of certainty and enigma simultaneously for the therapist. A strange time of feeling as though she were standing apart from her client/s yet with them still. A kind of therapeutic no man’s land where clarity and ambiguity co-exist.

Cara’s second descriptive excerpt also seems to depict a sense of fusing with the client/s. This idea of merging with the client through collaboration was touched upon by Cara when she went on to say,

“then if you see yourself as like if you use the metaphor of the accompanier or like the companion in the journey then I guess the connection is part of it I suppose but if you see yourself as separate from the client as yourself as an expert and they are coming kind of for you to give them some kind of service I think you'd position yourself different, you wouldn't even want the connection I suppose” (Cara).

Similar ideas were also highlighted by Ilaria who interestingly also used the same therapeutic metaphor of the co-traveller to elucidate her own thoughts about relational connectivity when she said,
“I would say that I would be there as a person who is going along the journey with the client so I would want to look at it as a collaborative position, that I would want to walk along with the client and that there would be moments when I would be holding the client in a way and maybe also directing them at other times but focusing on creating a you know an equal kind of relationship. I wouldn't want to be seen by them and I don't want to come across not even as a superior or authoritarian or authoritative having a higher position in some way than them, I respect the client as the experts of their own life”. (Ilaria)

Adding to this theme of fusing with connection and the client/s Ilaria also described the feelings of connection as “being in it”, or, “getting lost in it”.

“It's easy to get lost in the connection sort of that's our responsibility as therapists to create the boundaries around the relationship to evaluate the connection and to reflect on what is going on as well”. (Ilaria)

Connection for these two respondents seems to be a place of intrigue and to some extent therapeutic uncertainty. A necessary place to go to with the client/s but one in which their wits as therapists are at the forefront of their experiences.

4.6.2 Connection as the main source of therapeutic healing

The majority of the participants all seemed in one way or another to identify connection in the therapeutic relationship as the most influential aspect of therapy and change and that these pivotal moments shared with clients in practice were mainly responsible for transformation or shifts.

It was interesting to note that one respondent Ilaria particularly used the analogy of “healing hands” to articulate how connection and human contact were at the basis of her therapeutic work with families. She saw her therapeutic positioning in the work to be as follows,

“The hands that hold and that they can keep tight but they can also release somehow and I think that’s what happens in therapy, you hold clients sometimes you hold them a bit more and then you have to release them and push you know help to guide them to move ahead and take risks and you know grow and evolve if anything”. (Ilaria)
This metaphor could also serve as a comparison with the different phases of dialogical focused therapeutic work. It reflects aspects of the respect, pace and emotional attunement at the heart of dialogical positioning.

4.6.3 Interdependency between therapeutic interventions and connection

In this sub-theme, a relationship was noted between the respondents use of strategic and intent driven interventions designed to join with their families. This particular theme highlighted how structured and aesthetic aspects of therapeutic work can be used together to connect further with families. This aspect was captured eloquently by Rula when she said,

“unless you are able to give that nurture than it's very difficult for you to develop that kind of connectedness and you do it in every way like for example in being reliable, in being there for the client, in you know containing the client even sometimes even in the way that you give appointments and you stick to your appointments and you know there is a continuity from one session to the next”.

…I aim to connect with my clients”. (Rula)

Rula further elaborated by narrating how an awareness of how shared connective moments with families seemed to provide a window of opportunity for deeper or more sensitive therapeutic interventions to be carried out by herself, helped her to be more creative in her method of making contact with clients.

“I have these moments of connectedness which allow me then to kind of intervene”. (Rula)

Rula also went on to highlight this interplay of theory with connecting with clients by sharing how her own ability to connect systems in her head contextually and relationally allowed her to grasp a richer contextual understanding and picture of her client/s needs. This helped her to tailor her interventions to meet the needs of the client more. She felt that learning how to use theory in this way eventually tended to lessen the distance between therapist and client/s thus aiding more connection in the long run.
“So even if I'm working with something like anxiety I understand anxiety as part of a system you know so it's not just the individual and his anxiety but the individual and his anxiety in the context of the system”. (Rula)

4.6.4 Lack of contact with clients seen as indicative of lack of connection

It was also evident in this subordinate theme that therapeutic barriers/breakdowns and lack of contact also sometimes highlighted to the therapist a need to re-connect with the system by checking with themselves and their own connective process what was going on.

Some participants reported that if they did not attend to these ruptures this could lead to them either becoming over invested in the client’s situation, or totally disengaging from it out of feelings of being overwhelmed or uncertain how to proceed. In this regard, Rula, offered,

“when I am not in contact then I start asking what is happening you know when I'm not in a relationship, when I'm not having that kind of connection and I say what is happening here if I find myself I don't know not thinking about the client or you know not listening enough or just having my thoughts wander off then I start worrying and I start questioning what's happening and I would know that it will be just with that client because in the previous session with someone else I was very there. So then I start thinking OK what's happening here, what's this loss of contact here so that's how it works”. (Rula)

“when I get stuck in a way in certain sessions and I try to think why am I being this stuck? What's the client bringing to the session and what am I bringing to the session? How come I lose my curiosity in a way and in trying to change my positioning usually the fact that I become more curious and I try to sort of change my hypothesis and try to listen more, usually that helps quite a lot in terms of my connection with the client”. (Claudia)

4.7 Resonance with life scripts

This superordinate theme depicts the process that occurs when the respondents of this study were presented with parallel aspects/stories to their own personal lived experiences in their clinical practice and how this impacted them in
terms of their connection with families. The effect that such occurrences have on them personally and on their therapeutic role will follow.

The majority of the participants shared that their role as clinicians had been somewhat influenced by the challenges they themselves had experienced in their relationships with significant others whilst growing up. They added that clinical involvement, life experience and personal work on their own stories through personal therapy and supervision created the much needed space necessary for their private and public identities not to clash yet to remain connected.

Elenora in particular spoke at length during the interviews and stressed how because as a child for the most part she had felt misunderstood and ignored or unseen in her childhood, this impacted her need to privilege, value and give time to children’s perspectives in her therapeutic endeavours whilst practicing family therapy. She felt that this way of positioning herself therapeutically made her more accessible to these types of client/s in general.

Elenora also saw her professional role as being one in which she replicated her own corrective emotional experiences with the clients she worked with by being the positive person to them that she had once known herself through the various positive mentors or role models that had been in her life. Elenora felt that the validation she was now able to give to people in therapy was a result of this interweaving of working through her own story coupled with respect for the client/s. She felt that this element of therapy was what particularly motivated her and enriched her therapeutic work with families. It also helped her to go forward and forge further connections with her families.

"as I was growing up I always felt that genuineness and authenticity and really being there with the person and seeing them so that they can feel seen and validated was something that I missed and because I missed it I did not take it for granted"

...“in simpler words I remember myself saying 'I want to help children to feel understood because this is what I need to feel'.

...“I think what I feel more appreciative is for feedback that I'm given when I'm told that they experience me as genuine in what I do and my emotional reaction to that feedback when they tell me that they experience me as genuine shows me that I value that quality, that is the lens that I adopt in my
way because the feedback that moves us or that is important to us has a lot to do about what is important for us and I think because I value a lot genuineness and authenticity and the ability also to feel seen and validated is the reason why when I am given such feedback it really resonates with me because I guess it kind of proves as a validation that what I really look for in relationships myself I am able to bring in to my work. So in a way it keeps confirming to me that what we're interested in, even what we're interested in as professionals in terms of what we like to bring in our work has a lot to do with us”. (Elenora)

Another participant Ilaria reported that when she experienced resonance in her work with families this was actually when she herself felt most connected to them. She also commented that she tried her best to keep the needs of the family at the forefront of her mind in these moments, this centrality of focus was what she felt kept keep her own issues separate from the client/s but at the same time this did not limit or hinder the therapeutic engagement and connection.

“I then think that also when something is similar to my own either a similar story of something which is of a similar experience, the connection is greater”

“I would be more attentive but the connection is felt in a particularly different way”. (Ilaria)

4.7.1 Therapists’ own life scripts seen as determinate in the preferred theoretical choices

Interestingly, this sub-theme highlighted how the participants felt that their own life stories influenced their attractions to particular theories or interventions. Some of the respondents even felt that these theory driven choices were what informed their question formulations in practice. Being sensitive to client’s stories that resonated with their own also seemed to impact their preferred theoretical approaches and interventions. What was significant to also note from this was that instead of this resonance being experienced as emotionally burdensome, some of the respondents actually narrated how this level of connection in the work acted as a catalyst for them to further appreciate the way that these personal learnings could be used to make better contact with their families. The participants felt that these reflections were what supported them to remain curious as professionals and to sustain relational contact with their families.
Elenora for example, said that her preferred therapeutic modality of choice was to draw from an attachment and resilience focus in her work, this was because she felt that when she used these approaches she was being true to herself and also theoretically sound. She used a very powerful statement to highlight the interplay between one’s theoretical underpinnings and one’s personhood as a therapist. She said, “change happens as we speak”. (Elenora)

Recursivity was seen to be the link between theory-practice-personal reflexivity by her and the way that she made sense of her epistemological position. In this regard when she reflected on her own life story and theory preferences she commented.

“I would try to connect it with my own life initially and then as I started to work with other families besides my own in that sense I would actually link it to particular family stories that I would be exposed to and that helped me to consistently make practical sense of epistemology, to always move back and forth from theory to practice and personal reflexivity”.

...“families are always evaluating us”. (Elenora)

To substantiate further, she explained that her own childhood struggles had supported her to remain positive with children in therapy because in overcoming her own difficulties she now looked upon these deficits as a resource and something that she could tap into in order to reach children in similar situations. This resource based stance that she adopted with children helped her to elicit belief and self-efficacy from children who otherwise may have felt marginalised or helpless.

“I am attracted to attachment conceptual frameworks, I think I see them as positive in that regard because they allow the hope for change and for shift and they speak a lot about relationships and the ability to bring change out of the way we relate in relationships. So it affects me because it helps me to believe that change is possible and that change even happens through us as we experience relationships differently”. (Elenora)

“So ideas on scripts, ideas on essentially the rewriting of family scripts, ideas of attachment, ideas on resilience because there again the ability to focus on strengths and on resources are very powerful and empowering ideas to me and therefore I share them in my work because the way I understand epistemology is if it was good enough for me hopefully good enough then in my work with clients.”
...“connections occurring within ourselves as clinicians from our learnings about theories such as coping skills and strategies in attachment theory. We then impart this wisdom to client/s and foster further connection”. (Elenora)

Another respondent Claudia when speaking about her own preferred theoretical preferences had this to say,

“Well the fact that for example I give a lot of value to the therapeutic relationship and it obviously influences where I’m coming from, the work I do with the clients for example stuff like strategic approaches which Is more sort of directive definitely go; they don't come easy to me and I wouldn't really be comfortable using them, so my approaches would be more sort of in a way narrative approaches, listening to clients story, helping them to maybe find alternative approaches to their realities, sort of what they can do differently, what have they done in the past that has been helpful for them, so looking more along those lines. Again it's because of what I give value to in therapy and to the sessions so I would be looking, I will use more those approaches and those believes if you see what I mean rather than more direct”. (Claudia)

4.7.2 Theoretical underpinnings provide a sense of security

This subordinate theme deals with the level of reassurance that the respondents felt they had within themselves because of this deeper understanding of one’s theoretical underpinnings. Some participants reported that they had a sense of personal direction from this theoretically lived knowledge which then also contributed to their ability as professionals to contain and hold the clients stories and uncertainties. Respondents also described how they felt a need to balance out their therapeutic work with these lived experiences.

Cara in particular made reference to her own reflections about attachment theory as a practical theoretical balance to her work,

“for me that has influenced me a lot, attachment a lot at the moment it's something that I kind of find myself drawing from, attachment not in terms of attachment style, attachment as a survival strategy so I see how people have connected before and how those survival strategies may sometime become redundant and then how people fit together, what is owned, what is not owned”. (Cara)
4.8 Meaning making: The search for “truth”

As outlined throughout the previous themes, the participants stressed and highlighted the importance of being aware of their own process and experiences before they could be in a position to reach out to others in the work. In this personal way they could then become more aware of how this impinges on their professional therapeutic role. Respondents narrated how this was attempted in order to be more equipped to deal with the complexities their families presented with. Making sense seems to take place firstly within the lived and embodied experience of the respondents. It was seen to be a process and not a destination.

This superordinate theme also addresses the understanding that throughout the interviews the participants all spoke at length about the way that holding a dialogical stance with their families helped them to arrive at therapeutic places of connection that could be called truth.

Various respondents reported that this was a lot to do with touching base with clients often and a mindful checking about what was taking place in therapy.

4.8.1 Therapists’ providing a safe base from which client can be supported to search for their personal truth through connection and open conversation

In this sub-theme the participants expressed a need to provide the client/s with a contained place of safety for consideration of emerging truths or alternatives to their stories to be explored. In order to arrive here, respondents said that often they themselves had to free their minds of what would be colloquially referred to as “common sense” or their own judgements in order to locate some other form of understanding within them that allowed them to make contact with their families free from their own biases.

“I try to support people to make sense of their stories and to have space to hold different complex stories and make sure that this process happens in an accepting and non-judgmental way and that that in itself, the process of unfolding ones story changes happening as we speak”. (Elenora)
“what fits for them, does not fit for me”. (Claudia)

4.8.2 Constructionist perspective encourages the development of a mutual sense of meaning making

In this subordinate theme the participants shared their experiences of how their positioning in the system from a constructionist standpoint itself helped facilitate connection in the therapeutic relationship. This mainly happened as a result of the respondents seeing themselves as being collaborative and non-expert in their endeavours with their families. Their therapeutic roles were very much tied up with facilitation rather than direction.

“people are the authors of their change so as a therapist I can facilitate the change but I cannot push the change you know so I work with change”

... “Because I am open to whatever the change is going to be so the change is what the client wants to write in his story”

...“And whether that the change would mean X or Y I'm fine with both as long as there is no abuse or whatever but in the normal circumstances I'm OK with how change develops as long as change happens and I am there just to facilitate that process of change, to help the person think about change”. (Rula)

From these various excerpts the participants positioning in the system is one of an observer who can envisage change before it takes place, then through accompanying the client can then bring this vision into the client/s awareness.

Another respondent, Claudia was keen to share how sometimes she takes on the role of being the voice of her less privileged clients who for various reasons are less vocal due to marginalisation.

“Especially when it's clients who are quite low to middle class, I see they tend to outrightly say 'Oh thank God there's you, what would I do if you're not there”. (Claudia)
4.9 Seeing the past: to let it go

In this subordinate theme, some of the participants gave accounts of how they identified reconnecting with their own past experiences in helping them to meet and support their clinical families. Most of the respondents at some point in their interviews shared that their role as family therapists has also been shaped through the difficulties they themselves experienced whilst growing up. Losses and obstacles in their relationships with significant others were highlighted as possible contributory factors to their choice of career. However, these somewhat negative experiences served to offer various participants a different more hopeful way of engaging with the complexities they encountered in their work with families. These personal lessons often facilitated the participants to offer a more positive story or narrative to their clients when they were encountering similar absences or losses in their own lives.

4.9.1 Allowing one’s own past pain to act as a key to unlocking how therapists reach the pain of clients

To elaborate on this, Elenora shared a clinical experience of how she communicated to the client that she had truly understood their pain by re connecting with her own past losses herself, the following excerpt is based on feedback she received form a client about the way they experienced her,

“They could mention examples for example when I shared that difficult complex story of my past I felt that you were accepting, you were not judging me, I saw your face when I mentioned those specific elements in the story, I didn’t see you cringe like I could have seen maybe some other person in my life. Even the words that you chose show me that you truly understand, that you truly have compassion and they would also usually cite examples that counter act that narrative, for example they would mention episodes in their life when they could have tried to share such a story and the response they were given either by a family member, a friend and sometimes by maybe other professionals as well, where they felt that maybe they were being judged or that they were being dismissed and they make it a point to pinpoint what exactly I did or did not do that made them feel understood or misunderstood.” (Elenora)
4.9.2 Letting go of one’s own beliefs and judgements seen as a vital element in facilitating connection with clients

In this sub-theme various respondents described how in order to let go of their own judgements and biases they often tried to connect thematically with the subject matter in hand even if the area under scrutiny in therapy was not necessarily something that they shared common moral ground with the family/client on.

Claudia spoke about how when she found herself in difficulty of losing connection with her client/s she would attempt to disengage from her cognitive thoughts and try to engage with the client/s thematically and on an emotional level. In this way she was able to connect with the client’s pain and put aside her personal interpretive script or frame of reference.

“But then when I changed my perspective and my positioning because I realized I wasn’t going anywhere I started to connect a lot with her pain of the loss of motherhood and what did that mean for her”,

“OK, the fact I put, changed my position and there’s been that level of connection.” (Claudia)

This also happened when she found herself in difficult waters therapeutically when she found herself morally opposed to decisions that the client was making on the same theme of motherhood.

“I mean I remember even abroad working with a mum who wanted to do abortion and for me coming from discussion 'How can you ever support here and saying she is doing the best thing in the world that you could ever do, abort?' but all these in a way I realized how they were impacting on my relationship with the clients and my values were definitely not helping the engagement and the connection that you can ever have with clients”. (Claudia)

4.9.3 “I listen more and I connect”

“I am with them” (Claudia).

“I listen and I don't judge them so they feel safe, they've mentioned several times that how safe they feel and that they can feel vulnerable to be whoever
they are because they feel this is one of the only places they could be that vulnerable for example so probably I would imagine this is what they would say. That it is a safe place to be, that they can grow in". (Ilaria)

4.9.4 Notion of redundant therapist: stepping away to allow clients to sustain themselves

In this final sub-theme, notions of invisible yet present therapist/s were shared. The role of the therapist was seen to be one in which the client carry’s their memory with them but no longer needs their physical presence in their life.

‘therapy is about helping the person in front of you learn how to sustain himself or herself without you being there any more you know. I always aim to become redundant so you know my idea is that whatever I’m giving, the person”

“the person needs to kind of make sense of it and make it his own and then be able to go out in the world on his own without me you know so I will be the water for the plant to start developing until it can sustain itself and then it can go”.

“I help them believe that whatever they're going through at some point it's going to be OK, that OK I don't know what it's going to be but it will be OK you know and that is something that they all say that really helps them“. (Rula)

4.10 Conclusion

The excerpts outlined in this chapter show a range of connections between the therapeutic experiences of the participants, and their clinical practice. Participants seemed to emphasise and stress that it is crucial for family therapists to identify these connections and reflect on the possible ways in which these links can influence their practice. The family therapists interviewed also highlighted the significant role of their use of humanity, the selfhood of the therapist, resonance and the importance of attending to their emotional and embodiment process in relation to connection with their clients.
In the following chapter, I will discuss the findings of this study in the light of the selected literature that discusses the link between personal experience of family therapists and their therapeutic work.
Chapter Five
Chapter 5. Discussion.

5.1 Introduction

This exploratory study was designed to shed light on moments of connection with clients during therapeutic work. The outcomes that emerged from the contributions shared by the five family therapists interviewed indicate a variety of perspectives about this connection. Therefore, the aim of this chapter is to discuss the salient findings that have been elicited from the themes and to give meaning to the participants’ reflections on the link being explored in this study. My reasons for selecting these particular themes is namely because on a personal level, I wish to be true to the nature of this methodology and allow my voice as the researcher to be present, and also because of other practical and mitigating factors like the word count which limits me somewhat.

5.2 Positioning Myself within the Research Researchers position.

In line with systemic practice and my research paradigm and strategy, the social constructionist position emphasizes the need for the researcher to claim their own position within the research (Guba & Lincoln, 1994). Therefore, the position being adopted in this study is that therapeutic connection is grounded in our relational positioning with clients, and may be accessed through our therapeutic use of self, and that the therapists’ personal emotional and embodiment experiences can serve as one of several contexts by which they can understand their own clinical practice and relationships with clients. This may also be because in order to connect with clients we perhaps must first learn to connect with ourselves through our own vulnerabilities.

I intend to adopt a tentative stance because throughout this research process I was aware of the fact that as a subject area under investigation, the qualities tied up with expressing the phenomenon of connection remain a very subjective and relatively elusive thing and thus are difficult to capture definitively. Also, I am attempting to discuss other’s voices through my interpretation of these, and my say may not or
should not be the prescriptive last voice of this subject matter. Perhaps, this may be
the way that this “subject” should be looked upon and revered. As such, this is
merely and humbly a provocation of sorts for further study into the magical area of
counter.

5.3 Connection: A Primary Human Need.

As way of introducing this first part of the discussion, I would like to
orientate my reader/s by informing them that I thought it would be appropriate to
orient the superordinate themes of “Connection is a firstly human endeavour” with
“Therapists’ have inner calling to become therapists. I felt that in doing so I could
orient the interplay of the self as human with the self as professional in a
therapeutic way by showing how just as the therapeutic relationship develops over
time according to how the therapist uses their self to facilitate clients, in a parallel
process similar to this, the therapist’s own development evolves too over time as
they learn to integrate these two aspects of self into one way of being.

I would also like to assert that the values that I give credence to in my personal and
professional life, like honesty, integrity and authenticity, are also reflected in these
orientations. For all these reasons, the tenets of the humanistic and dialogical
approaches seem best suited as way of addressing the basis of my discussion and so
the stance of these conceptual models will be assumed. I will address findings
which struck me, and which resonated with my own preferred relational stance in
therapy.

5.4 Use of self of the therapist seen as a vital component of therapy

To highlight the value of a particular theoretical position, according to
Combs (1989), is to provide a frame of reference for the effective use of self. This is
mainly because, success or failure as therapist is dependent on the use of his or her
self as a catalyst for client change. Fundamentally, I attach great importance to this
human aspect of therapy because the use of self has been recognized by various
therapists as being the single most important factor in developing a therapeutic
relationship (Andolfi, Ellenwood, & Wendt, 1993; Baldwin, 2000). In true
humanistic fashion, using the self in psychotherapy or this “being with” process reflects those attributes of humanistic psychotherapy listed by Rogers as the “characteristics of the helping relationship” (Rogers, 1958). Also, being with in therapy occurs on multiple levels but it fundamentally starts with and from the self.

Throughout these findings, all the participants stressed from the onset that their primary connective medium was through their use of self, and this was expressed as being a firstly human activity. The main tool of a humanistically-oriented psychotherapist is the concept of the “self as instrument” (Combs, Avila, & Purkey, 1978). The use of self is the only tool available to us (Real, T. 1990). Learning to use the self as instrument might be facilitated by accepting the model proposed by Rogers (1959) which maintains: (1) the communication of congruence, empathic understanding and non-judgmental respect are necessary and sufficient psychotherapist activities, (2) that self-actualization is the motivation for human activity, (3) that each individual has the capacity for self-actualization, and (4) each therapeutic relationship is a creative and unique process.

This position was also assumed by all the research candidates who in varied ways illustrated how they could not actually carry out any therapeutic work until they had established these core conditions with their clients. “I think it's the basis of our work I mean relational connection is what therapy is based up really so unless you can develop relational connection you cannot actually have a therapy you know”. (Rula)

5.5 Personal and professional life experiences of therapist viewed as creating therapeutic connection.

A major finding of this study indicated that part and parcel of being an effective therapist was very much tied up with being able to firstly care for oneself. Virginia Satir who was a major contribution to the humanistic field, saw self-care of the therapist as being directly related to their self-esteem, and she saw this as the foundation of forging and creating connections both with oneself and with families. She asked a simple question of her students, “How do I feel about who I am?” (Satir, 1983). In this very human way the link between the private and the professional worlds becomes less blurred. After all, feeling good inside on a human level usually
helps us as professionals to take better decisions, better risks, to trust our own feelings more and so on.

One participant, Cara reflected these thoughts by saying, “you have to know where you start and where you finish and then you can be in a relationship”. The concept of self-care of the therapist is also an important factor to consider because if therapists are to promote the health and wellness of their clients, then they must also be actively pursuing this in their own lives. The flip side of this is if not attended to is “compassion fatigue” which can drain therapists’ energy, and foster discouragement, irritability, and depression (Pieper, 1999). Self-care and self-awareness also promote resilience because as the therapist acknowledges their feelings then life energy would be able to flow more readily, which means they would be more able to connect with self (Satir & Banmen, 1983). Cara also provided a very good example of this relationship between self and therapist when she described how if she did not take care of herself she would feel drained and depleted. “for me it's very emotionally engaging, very emotionally intense. For me therapy is not just cognitive, it involves a lot of emotions, it involves me my whole person hood kind of thing so I feel very tired, I feel like you know some kind of energy has been sucked out of me you know”.

Rogers (1958) was also of the opinion that any therapy based on the withholding of self as a person and dealing with others as objects does not have a high probability of success. From a dialogical perspective, in using the human aspects of the self of the therapist, a deeper alliance may be forged with the client/s that is based on mutual respect and trust. Perhaps this is because in order for clients to feel safe enough to disclose they need to feel sure that the therapist can use this information therapeutically so developing this trust remains crucial. These qualities of the therapeutic relationship corroborate with the literature already provided in the literature review and are what form the basis of the “I-Thou” trusting relationship beautifully described by Martin Buber (1937) that is the heart of humanistic psychotherapy.

The findings also indicated that part of connection with clients is felt through feelings of common human suffering that is shared between therapist and client/s.
“You are alone in the struggle, I can't go you know but at least we're kind of in it, it's not, you're not crazy, it's part of humanity, it's part of human suffering”. (Cara). In sharing her self-hood and vulnerability in this way the participant manages to bond herself to the client in a touchingly humble way. These types of disclosures in therapy can enhance connection in therapy, because they close the professional gap and elevate the clients from a one-down position in the therapeutic relationship. As Roget Lockard said, “You (the client) and I have a certain formal relationship that positions me in relation to you as an ally, hopefully a capable ally. But the bottom line, and the centrepiece of the relationship, is that we’re both human beings” (Diamond, 2000, p. 267). Dialogically speaking, these moments of coming together are classic I-Thou moments from a Buberian perspective. There is a coming together which takes place on an individual level, along with a coming together with client and a coming together of what is co-created between these things.

This stepping in and out fluidly between the realms of the personal and the private is also another example of how engagement with the system helps to elicit these active I-Thou dialogical encounters. The findings indicated that this way of positioning oneself in the work allowed for both a facilitative and also a participatory role of the therapist in the process of meaning making and change through conversation. Participants implied that they would ask themselves how can I position myself more to accommodate the needs of the client/family. In this way, from a systemic perspective, the findings also indicate that participants were also very aware of the many contexts and emotional currents present in the system. However, this getting in touch was still very much a human endeavour based on the dialogical principles of mutual respect and being sensitive to clients’ needs. This element was expressed by Claudia, when she said “when I get stuck in a way in certain sessions and I try to think why am I being this stuck? What's the client bringing to the session and what am I bringing to the session? How come I lose my curiosity in a way and in trying to change my positioning usually the fact that I become more curious and I try to sort of change my hypothesis and try to listen more, usually that helps quite a lot in terms of my connection with the client” (Claudia)
5.6 Therapists defined as sensitive towards the pain of others

As has been stressed throughout my discussion so far, the human aspects of therapeutic connection cannot be undermined. In the findings it was also displayed by the participants that as they became more and more fully absorbed in the process of being human, their fragility also became exposed. This may have been connected to the universal ability they shared as humans with their clients to experience feelings and emotion. When these feelings were accessed in the participants, they found that in essence they could reach out to another human being in the spirit of this joint commonality. This was particularly evident in the findings during the connective aspects of experiencing painful moments in therapy with clients. This led me to hypothesise that this may have been because painful emotions also tend to elicit strong feelings of sharing and belongingness too. These shared feelings of solidarity could have made it permissible or possible for the participants to intervene at a deeper level, and make it then also possible to go more deeply into further pain and therapeutic work.

Dialogue occurs as if by itself when painful emotions are not treated as dangerous, but instead allowed to flow freely in the room (Trimble, 2000; Tschudi & Reichelt, 2004). These thoughts were aptly illustrated by Cara and Ilaria respectively “Sometimes I had clients where I really felt I accompanied them in their sadness and I felt sad myself, I felt burdened, I felt heavy” (Cara) “usually it's moments where there is deep pain, where there is this you know it's clear the pain can be felt, it's very raw and obviously I'm very touched in those moments when the clients share something which is especially painful for them”. (Ilaria)

The participants reflected upon how as therapist they felt that they grew from these shared affective experiences of recovery and commonalities with their clients. They also stated that another advantage from positioning themselves this way therapeutically with clients was that the clients had an opportunity to view them as not perfect and far from pristine through their shared existential experiences as human beings. From a humanistic perspective, empathy is the ability to see the world through the eyes of the client. This primary skill is at the centre of the therapeutic process. Empathy is so important that Rogers (1958, 1959) named it first among his three necessary and sufficient conditions for professional helping. He and
others (Greenberg, Rice & Elliot, 1994; Purkey & Schmidt, 1996) regarded empathy as the basis for everything that happens in therapy. To be empathically sensitive to the hidden self of the client is necessary to “read behavior backwards” (Combs, Avila & Purkey, 1978). Satir believed that people make decisions based on both the conscious and unconscious worlds, and she encouraged therapists to hear with their “inner ear” and to see with their “inner eye” (Reik, 1948; Satir & Banmen, 1983).

What I experienced myself as I tried to give voice to the participants’ experiences of pain with their families was that as humans when we experience our own losses these voices of loss and sadness become a part of a bigger kind of presence in our beings and ultimately our therapeutic work. Even, although, as therapists we are not necessarily always able to share or disclose these personal moments of our own pain with our clients, we can still adapt our embodiment and response process to convey to the clients that we understand their pain. By focusing on the here and the now in the room we somehow align ourselves to their suffering. The ethical responsibilities tied up with modern day constructionist therapy are also concerned with us listening to these voices, and perhaps most importantly, to our own inner voices of vulnerability and triumph over adversity. In this way we can extend ourselves dialogically to our families. “I extend my hand, my training, my experiences and I say 'look I've gone through this and I can really witness and I can really maybe you know in sharing some of what I went through, a little, maybe you can understand that you're not alone in this'”. (Cara)

5.7 Sense of marvel about humanity

“ I hold myself to have learnt about life and relationships through all these different people. I guess there was a time when this connection with the people was experienced by myself as burdensome, now I guess I am hold more of a spiritual existential position I suppose but it came through time and maybe through me getting older, I don't know I mean it's something it's a work in progress you know”. (Cara)

The findings of this study also indicated another dimension to therapeutic work, that of spirituality. Some of the participants felt that their own humanity was enriched and elevated by the learnings bestowed upon them in their work with clients. Cara
stated, “there are times when I marvelled at their resilience or they taught me a lot and I guess having this connection with another human being through therapy is a way of giving meaning to my life” (Cara). The family therapists of this study shared how their ability to self-reflect in this way about how they were effected by their clients experiences in therapy helped them to develop a sense of congruence and groundedness about their lives and their work. This type of inner world awareness recognises that groundedness would facilitate a sense of connectedness to others (Banmen & Banmen, 1991; Satir & Banmen, 1983).

Satir saw therapy as a spiritual experience between herself and her client. In a way it’s about the therapist honouring the existence or the essence of the client and this awareness is the key to moving people from an incongruent state to the state of congruence (Lum, 2000; Satir & Baldwin, 1983). Congruence is seen as a state of harmony, clarity, and honesty. Congruence would be the result of the therapist trusting oneself (Baldwin, 2000; Lum, 2000). “How much am I willing to trust my hunches?” When therapists are congruent, then they are more able be more grounded and stable as they help to support their client’s change (Satir & Baldwin, 1983). Lowe (2005), refers to these special moments in therapy as ‘Striking moments in dialogical exchanges’, with Katz, (1999), earlier on referring to them as, ‘Living, poetic or arresting moments’.

The development of the self of the therapist remains an area that is often overlooked in therapy (Baldwin, 2000). Perhaps a way forward for more congruent intuitive therapists is to embrace the humanity of these professionals Kramer (2000) suggested that the secrecy that surrounds the discussion of self of the therapist has contributed to the inadequate preparation of future therapists. Meanwhile, the search for self in psychotherapy is a fragile and tantalizing journey, where clients and therapists work together in a voyage of discovery.

5.8 Resonance: Bringing it all Together.

In this segment, I would like to focus on some of the themes of resonance that surfaced in the findings chapter and link these with themes from’ seeing the past
to let it go”. Presently, I will elaborate on why I chose to synthesize these aspects for discussion, always keeping in mind the connection between the human and the professional factors involved in the challenges and blessings of our therapeutic work.

“…there would be some lectures where I would actually get emotional when they would start to discuss concepts that move me”

...“many of us in the work are drawn to this because of our life stories and these are what propelled us to become therapists”. (Elenora)

As therapists we seem to connect first with deficits in our own life on a human level through our awareness of our own vulnerabilities that are present in our scripts and stories. This then informs us theoretically and underpins our work ethos, and sometimes, through our own reconnection with our own disconnections, those painful absent needs that reside within us all are resurrected once more through the hope, nourishment and resilience that our work provides us with. Sometimes these factors are even what propel us into becoming helpers and therapists in the first place, and in a very human way, it’s often where we finally find our sense of home and connection once more. This can come to us through the validation and acceptance our work and our clinical families generously bestow on us. These personal understandings and insights in a reciprocal fashion are hopefully what allow and facilitate us into identifying how we can then best reach other families in practice too.

Linking these thoughts to the findings, an understanding of resonance is a vital and integral part of therapeutic understanding and practice, because if the therapist concerned can reflect on how their own stories and relationships position them in terms of hindering or supporting them they may be in a better position to reach out to their families in practice by establishing healthier therapeutic alliances (Aponte, 1994).
5.9 Therapists’ own life scripts seen as determinate in the preferred theoretical choices and interventions

To help highlight the findings in this part of the discussion, and to accentuate the interplay between one’s preferred theoretical underpinning with one’s story, practice and self-reflexivity, Byng-Hall’s theory on scripts (Byng-Hall, 1995) provides a good context for demonstrating the overspill each of these domains have on therapeutic practice. In Bateson’s (1979) idea context is our mental or psychological frame of understanding for our own life and experience. It also serves as valid point of departure for how the therapists in this study arrived at meaning in their practice. Context in this sense means, the resonance between the therapists’ personal and private life and therapeutic practice and how it affected their understanding in their therapeutic process.

This resonance focus also serves to heighten the emotional components of the findings which is also in keeping with the emotional focus of this research. Resonance as an emotional concept in therapy can be thought of as the emotional state/story presented by the family in therapy and how this might affect the therapist leading him or her to repeat their own scripts (Byng-Hall, 1995). Byng-Hall (2008) recommends that therapists become comfortable with their own family scripts so as to become familiar with any possible circumstance that might provoke an emotional reaction in them or lead them to adopt a particular attitude towards the family situations present (Byng-Hall, 2008).

As a concept in general, resonance was developed to give a clearer understanding of what happens when families put forward stories that trigger the family therapist’s own personal and private experiences (Jensen, 2012). This is what is known as reciprocal resonance, “where the client’s history or situation recalls memories and emotions by the therapist that connect the therapist and the clients to a common reference” (Jensen, 2012, p. 74). In this way, the concept can be used to understand more the challenges this places upon the therapist in practice.

Another concept that I found useful when trying to interpret the cumulative effects of resonance in the findings of the participants was Per Jensen’s (2008) map of
relational resonance. This also helps to bring to light this connective interplay of the therapist’s private and public and emotional worlds, and it can also give a deeper theoretical understanding of how these factors were experienced by the participants when they encountered parallel process or similarities in their practice.

For example, in the findings, the participants explained that when situations in therapy resonated with their childhood adversities they felt over involved and their ability to remain objective was sometimes threatened. Elenora described her reactions in therapy when a situation presented that was similar to her own negative childhood experiences of feeling invalidated or ignored this caused an emotional trigger in her and she felt the need to become the voice of children in her work. She outlined that in her family of origin as a child she had felt “misunderstood” and “not seen”, so she had learnt to look outside of herself and her immediate family for validation through mentors and other significant role models that were present in her life. This may have been theoretical evidence in the findings of the corrective scripts spoken of by Byng-Hall (1995). This is where significant others provide people with a different emotional experience or parenting experience to the one that they had received which was experienced by them as unaccommodating to their emotional needs.

Elenora explained how her own corrective emotional experience from her own past had influenced her role and positioning in her therapeutic work with children. In her positioning she tried to maintain a resilience focus based on strengths over adversity, and in this way replicate a corrective emotional experience to her clients. In her work she privileged the voices of children. Because of her own growths and triumphs over adversity, in therapy this translated to her having a very positive outlook with clients undergoing similar circumstances. This led me to reflect on the link between the personal and the professional aspects of practice once more and how the direction and the intent of therapeutic interventions are rooted in the human aspects of our epistemologies. Elenora’s belief system around difficulty learnt in her childhood, in therapy positioned her as an optimist and a survivor, and she electively chose to embrace change during therapeutic tough spots. However, this also made me aware that even when the therapist’s intentions are good, the direction of their work may be very much tied up with their personal beliefs and influences and
ultimately this will steer interventions one sidedly. This might be also evidence of what Jensen (2012) refers to as “indirect therapeutic colonization” (p. 75).

The idea of “therapeutic colonization” (Jensen, 2008, p. 204), being that a family therapist’s own culture, lived experiences and values might impact their therapeutic work. When therapeutic colonization takes place, the therapist uses his or her own experiences to determine the themes to be discussed in therapy, regardless of what the families want or may need. “In this way the sphere in which reciprocal communication operates is reduced” (Jensen, 2012, p. 76), thus interfering with the collaborative stance that is aspired to in systemic work. Connected to these thoughts, I could not help but also notice how at different times during the analysis of the audio tapes of the various participants, I was most aware of how out of all the respondents, Elenora’s voice seemed the most certain at times. In fact, her interview was the longest in duration also. This may have also been a reflection of her chosen or preferred way of working and going forward with her families. The flip side of this however could be that in being so sure she may have overlooked other possibilities thus impeding her ability to take a “not-knowing” (Anderson, 1990, p. 195) stance also in the work. Other theorists, like Mary Main (1996) have however, highlighted the importance of developing a coherent story around our adverse circumstances. From a constructionist perspective, an ability to develop coherence around our own stories helps us as therapists to create new meanings of understanding with our clients. Martha Rogers (1970) likes to take a more liberal approach to resonance as a therapeutic phenomenon saying that resonance with the environment sometimes may be “harmonic, sometimes cacophonous, sometimes dissonant …” (Rogers, 1970, p. 219).

Dialogically speaking, a therapist can and should work with whatever the client presents them with, and these various dynamics in therapy help us as therapists to identify our own needs and this means that we need to have the ability for reflective functioning (Fonagy et al., 1991). Also in being able to work through adverse childhood events such as those described by Elenora, having such awareness might help the individual to develop a more secure sense of self (Fonagy et al., 2004). In terms of connection in therapy, being secure supports individuals to understand
themselves and others (Fonagy & Target, 1997). This is an important competency when working with families in (Flaskas, 1997).

As I reflect on my learnings from this segment of the discussion, I am inclined to think of resonance as another complex layer to the web of connection and understanding that is taking place within therapists as they try to make sense of their client’s dilemmas. The same personal experience however can be experienced differently by any given therapist, and this highlighted to me the need for therapist’s to constantly reflect on their positioning in any clinical situation or system. In such situations when resonance is present between the therapist’s story and the client/s, a deeper contextual understanding is needed, otherwise the therapist could run the risk of becoming biased with their own emotional stories and this emotional assault could then limit their ability to take into consideration the different contexts involved. Thus, family therapists need to reflect constantly on how their personal experiences might influence their therapeutic endeavours with families.

5.10 Making Meaning: through Embodiment.

“I listen more and I connect” (Ilaria)

In this section of the discussion in order to highlight the link between meaning making and our embodiment process, conceptually, I found it useful to group themes from “attunement to the embodiment process” with “Meaning making: the search for truth”. In order to explore this relationship further, I intend to use constructionist positioning and also draw from Bakhtins ideas on dialogical, or creative, understanding (Bakhtin, 1986). Perhaps the epistemological reason for my choosing to interpret the participants findings in this way is because at various points in my own life for different reasons I have known the feeling of being misunderstood. However, through using Bakhtin’s frame for understanding I have come to know myself better and form a more coherent picture around how I may have contributed to this process, and how it now positions me in my work.

To Shotter and Lannamann (2002), social constructionism should include a more relational component in its definition. They argue for a version that embraces the
nature of the “living, embodied, reciprocal spontaneity that constitutes social interaction” (p. 579). One that rejects, mechanically structured, and calculational activities. In their view, “social construction, although occasionally done willfully… is much more often something that happens to us in the course of becoming an “us”…Construction is an inseparable part of the already existing shimmering dynamic of the ceaseless flow of relational activity within which we are inextricably embedded. When this spontaneous activity is left out, social constructionist inquiry is reduced to a vocabulary for naming the residues or outcomes of social interaction. (p. 580) Instead, they promote a responsive, embodied and participatory version of social constructionism that highlights the mutually determining flows of activity that act as precursors to our spoken words.

Bakhtin’s positioning, also defends a relational view of understanding in therapy, as he claims that understanding is not a passive process in which meanings are conveyed by the client and received by the therapist. Rather, understanding becomes an active, creative process in which the meanings of the client make contact with the meanings of the therapist. The interplay of outside with inside in therapy, was pointed out by Bakhtin (1986) as the possibility to see the world through the other’s eyes and “is a necessary part of the process of understanding.” He added, “but if it were the only aspect of this understanding, it would merely be duplication and would not entail anything new or enriching” (p. 7). Instead, the speaker is oriented toward a responsive, creative understanding: “In order to understand, it is immensely important for the person who understands to be located outside the object of his creative understanding” (p. 7).

This makes sense if we take into consideration also Flaskas (2002) thoughts on our embodiment process and it can be seen that having this outsider perspective is very important for understanding. Flaskas (2002) claims that if we understand ourselves as embedded individuals, then by implication we also define ourselves as embodied discrete individuals. As individuals, we experience ourselves as biologically discrete bodies contained within our skins (Flaskas, 2002). This may mean that we define our boundaries by our bodied self. Bakhtin (1986) even called this outsideness “the most powerful factor in understanding” (p. 7), because only outsideness creates the possibility for an enriching dialogue.
5.11 Experiential aspects of clients positioning therapists in being accommodating towards clients’ needs

The participants through their sharings in this study indicated that as fully committed professionals this also meant responding as as fully embodied persons. Perhaps because, often, the most difficult and traumatic memories are stored in nonverbal bodily memory (Van der Kolk, 1996), and so finding expression for this and finding meaning also means that as a therapist one has to learn how to contain and work with emotionality. Krause (1993) claims that the activity of any therapist involves dynamic and recursively-shaping interactions between feeling reactions and cognitive reflections, this dynamic process creates the evolving, individual and felt reality of the therapist. Understanding our felt reality is understanding the link between embeddedness and embodiedness. As way of highlighting the relational aspects of therapy, Bozarth (1990) cautions, techniques should emerge in the blending of therapist and client, otherwise they distract attention from the self of the client. Techniques should occur out of the relationship of the therapist’s self with the client self. In a way, the blending of the different aspects of the therapist provide the bridge for more structured interventions. In this regard, Bird (2000), speaks of needing a “language for the in-between”, that will highlight the potential for using structured methods in ways that are informed by relationally striking moments, so that our practice reflects both a directional and collaborative stance. In the findings, there was also evidence of this blending of technique and interventions with the embodiment process when Rula spoke of how she “aims to experience connection with my clients”.

For Seikkula and Trimble (2005) one of the main challenges in therapy for the therapist is to attend to the system moment to moment. Being present in the moment, as comprehensive embodied living persons, and responding to every utterance and thus living in the ‘once-occurring participation in being’ (Bakhtin, 1993, p. 2). It is so simple that we cannot believe that the healing element of any practice is simply to be heard, to have response, and that when the response is given and received, our therapeutic work is fulfilled (Seikkula & Trimble, 2005). The findings provided evidence of confusion in therapy or misunderstandings when this moment to moment presence was not attended to by the participants. For example, various
respondents spoke of examples of them being taken aback by clients’ comments about what they experienced as meaningful in the work, which was often not necessarily what the therapist had anticipated based on the therapists understanding of what they had done to be helpful to the client/s.

“I think, open conversation about what we are experiencing is very important to kind of avoid any misunderstandings because I know that, even I read somewhere in a particular study, what therapists might have experienced as meaningful sessions; 'Ah like this time I think it was a good session'; it's not necessarily obvious that it was experienced in the same way for the clients. Sometimes when I ask the families, like what was meaningful to them, they do come up with episodes that I might not have necessarily thought that they were that meaningful unless I had asked about them”. (Elenora)

“They could experience something which you have not seen or foretold so they would come and tell you 'you know what? Last time you really got me there' and I'd say OK, I wasn't like thinking about that but that made sense to him or her and it happened”. (Rula)

However, when attention to the shared embodiment experience between the client and the therapist was heeded to, in this immediate way, it was experienced as a way of helping the therapist to position themselves differently in the system by gaging the clients feelings. This helped orientate the next course of action/ intervention for the therapist. “I consciously would be seeking to develop, to focus on the relational aspect, how do I think the client is feeling at the moment, what do I need to do to help the client feel more at ease in the session” (Claudia)

In this regard, Daniel Stern (2004) also stresses the importance of the present moment, and he is critical of descriptions of psychotherapy that focus only on clients’ narratives. He is wary of this position in the creation of meaning in therapy because the therapist is seen as the one exclusively giving meanings to clients’ stories. In his opinion, from an embodiment perspective, therapy is far more complex, and it deals with explicit knowledge in linguistic descriptions. Stern proposes a way forward by moving from explicit knowledge to the implicit knowing that happens in the present moment as embodied experience, and mainly without words, that is, becoming aware of what is occurring in us before we give words to it.
5.12 Heightened level of physical awareness for both therapists and clients

This was experienced and felt by the participants too in the findings when they gave descriptions of moments of feeling very attuned and connected to their clients which then allowed them to proceed further “I have these moments of connectedness which allow me then to kind of intervene” (Rula)

This seems to imply a type of bodily awareness that does not seem to need words for understanding to take place. In this way, the contact between the therapist and client seems to take place through their shared, lived and embodied experience, it appears to also takes place outside of verbal expression and is an intuitive felt experience. There were other moments of lucid and heightened moments of sensory awareness prior to deeply intense or connective moments reflected in the research findings by other participants, “I even feel it like on a physical level. So sometimes I get the chills or sometimes I start to get emotional and I would want to acknowledge that and to try and understand what actually happened” (Elenora). Bakhtin (1984) claims that when we transform our bodily experiences into words they become voices of our lives. He further elaborated that when experiences are formulated into words, they are no longer unconscious.

As way of concluding the discussion I would like to share a reflection put forward by Rula regarding her view of her role in therapy. I think that it captures this lived and embodied aspect of our therapeutic work and it also offers hope over adversity in a very human way.

‘therapy is about helping the person in front of you learn how to sustain himself or herself without you being there any more.... I always aim to become redundant so you know my idea is that whatever I'm giving, the person... needs to kind of make sense of it and make it his own and then be able to go out in the world on his own without me” (Rula)

5.13 Conclusion

The findings discussed in this chapter seem to indicate that various factors influenced relational connectivity in therapeutic work with clients. These were namely that connection seems to initially take place on a human level, and that this is
also concerned with the therapeutic use of self which is framed in the collective embodied experiences shared with clients. These factors seem to occur on different and complex levels related to the private and professional lives of the participants.

The connections that emerged were compared with existing literature presented in the literature review, whilst also introducing new literature that could enhance further understanding.

In the next chapter, I will outline the limitations of this study and will put forward suggestions for future research. Finally, I will discuss the implications of the study and its relevance for the field of family therapy.
Chapter Six
Chapter 6.

6.1 Introduction

This chapter will outline the concluding comments for this study. It will present a summary of the main findings together with the limitations that have been identified along this process. Recommendations for future research as well as the implications for practice, training and supervision in systemic family therapy will then follow.

6.2 Summary of Salient Findings

The objective of the study was to explore the relationship between family therapists’ moments of connection in therapy with clients, and how this may ameliorate the change process.

The outcomes revealed participants’ perceptions on how they understood this aspect of the therapeutic relationship and how it impacted their practice as family therapists.

The findings are similar to existing literature, in that they outline the connection between family therapists’ use of self, with their embodiment process and personal experiences and practice.

This could be considered to be one of the main strengths of this research, considering that the existing studies were conducted in different cultural contexts.

In this way, the findings of this study may offer novel reflections about this phenomenon within the local context. Thus the themes elicited can be said to increase the knowledge base in this area locally.

The most prominent findings of this study are related to how family therapists make continuous use of self to access and connect with clients, and to facilitate change. This consolidates the literature in the family therapeutic field that highlights the
The central role that the selfhood of the therapist has in family therapy practice (Baldwin, 2013).

Interestingly, the findings also indicated that the use of self occurs primarily at a human level initially and that this ability to engage with clients in this informal way seems to have a facilitative role in the overall change process.

Findings also showed that the family therapists felt that through their work with families they had a deeper richer appreciation for the value of life and their own wellbeing and self-care.

Through their work with families, therapists felt that they were privileged to reflect more on their way of interacting with significant others (Heatherington et al., 2014). These claims further confirm the crucial need for therapists to take care of their own emotional wellbeing in their own lives in order to connect with others.

Therapists also reported that their growth has been enhanced by their shared learnings in their work with families in practice.

The findings indicated that the therapist’s ability to hold and contain pain and suffering with their clients was considered to be a universally bonding phenomena in therapy which also helped the therapist to maintain relational contact in their work with families.

However, this was also experienced as burdensome at times by the family therapists though this seemed to dissipate with time and the years of practice due to the physical maturation of the family therapist and work experience.

The outcomes also demonstrated how therapists’ own experience of adversity in life also seems to affect the therapist’s ability to understand and relate better with difficult emotions in therapy.
Findings highlighted how the therapists’ own experiences of adversity influence their therapeutic work by supporting them to deal with complexity, inform their interventions and instil hope in troubled families.

Past family of origin experiences such as childhood adversities, and difficult relationships growing up were also mentioned to be influential factors that contributed to their choice of career.

The therapists in this study also indicated that their embodiment process was a crucial tool that was used to access both themselves and their clients relationally in the work and which aided them in their meaning making with clients.

The study indicated also that these lived and embodied experiences shared with clients provide therapists with valuable life lessons and resources that could not be necessarily be accessed through their formal training.

The role of resonance in therapeutic work with families was also highlighted in the findings. The concept of resonance supports the understanding of the process that occurs when client families present issues that trigger or activate the family therapist’s own lived experiences (Jensen, 2012).

6.3 Implications for Practice

The findings have indicated that connection plays a vital and integral part in engaging with clients and facilitating the change process in therapy.

This highlights a professional and critical need for recognition of the significance of the use of self in therapeutic work.

This connective element seems to take place in many ways, primarily, through our use of self, and our embodiment process.

Resonance also seems to be an influential factor in these findings and how this impacts clinical practice.
This last point in turn has implication on practice, as it accentuates the need for family therapists to remain open to reflective practice to increase their mindfulness of how their own experiences position them in the therapeutic encounter.

Furthermore, the themes that have emerged can help therapists’ reflections by providing them with deeper insights into their personal experiences with clients which they may wish to explore further in supervision or in personal therapy.

6.4 Limitations of the Study

As previously indicated in the methodology chapter, I tried to foresee possible issues that could interfere with the credibility and trustworthiness of this study. Various efforts were made to ensure that limitations would be kept to a minimum. The respectfully collaborative stance of my supervisor who guided me throughout this research process in a way that was helpful for me was definitely a great comfort.

However, as the research progressed several limitations that could have possibly influenced the findings were identified.

One being that change by nature is to some extent an abstract and subjective experience and entity, and thus could be considered as elusive to capture or qualify for research purposes. This may be partly because every therapeutic experience is unique, as is every therapist. A challenge for me as the researcher was in trying to locate the essence of what change felt like for the participants’ of this study.

A pertinent and overriding reflection that accompanied me throughout the process of this research was related to the strengths and limitations of the fact that I was of a different culture to the participants. This made me reflect on how our different cultural frames of reference might have influenced the interpretation of data during the analysis process, and may have interfered somewhat with the meaning making involved.
Also, the local community of family therapists in Malta could perhaps be considered to be a relatively young and limited professional body, and so I also queried whether the fact that the research participants were all personally or professionally known to me would have compounded the analysis procedure in some way.

Recruiting a small sample of participants enabled me to explore in-depth the lived experiences shared. Consequently, I reflected how a different group of participants could have yielded different findings.

For example, all my research participants were female so the female voice in relation to connection was privileged exclusively by them as recruits and by myself during interpretation of the findings as the researcher. I wonder how the research would have been different had there been the presence and representation of the male voice around connection and change.

A pertinent reflection that accompanied me throughout the process of this research was related to the strengths and limitations of the cross-cultural aspect of the research. Although the participants were fluent in the English language, I wondered whether they would have been more comfortable speaking in their native language – Maltese. This made me reflect on whether this might have limited them in sharing as much as they would have. I wondered whether the data would have been richer had my participants been allowed to converse freely in Maltese. Furthermore, I reflected about how different cultural contexts might shape understanding and the behaviours and attitudes of the participants. The difference in our culture and language could have influenced my interpretation of the shared experiences thus causing a possible loss of meaning.

6.5 Recommendations for Future Research

The findings in this study could possibly indicate the need for further exploration of the therapeutic experience around connection within the local context.
The study could also be replicated using male participants to privilege the male voice in relation to connection and change in therapy and compare findings.

Originally as researcher, I had considered the possibility of researching the experiences of connection with both systemically trained psychotherapists and their clients, from these different standpoints, but after deliberate consideration of the time restraints and limitations, the word count, and the general vastness of the researched topic area, it was decided that the research would focus only on the psychotherapeutic experience of systemically trained therapists vis a vis their therapeutic experiences with clients.

This decision was also taken because as has already been explained in my research rationale, a position being taken is that the use of self in therapy remains an integral part of therapeutic connection as one’s relationship with self often informs one’s relationships and interventions with clients.

Thus it was deemed as being more informative in terms of future findings and growth full to the field of family therapy.

Such findings perhaps might support family therapists to extend their reflections in their training, practice and supervision.

An interesting theme mentioned by the participants was the recursive nature of practicing family therapy on their own life. There were times when therapeutic work was considered as a humbling and learning experience for family therapists. At other times, painful experiences with clients were experienced as burdensome by participants, so perhaps future research could be carried out to look into the impact of these traumatic experiences on family therapists.

Rosenberg and Pace (2006) stress the need for family therapists to be in touch with the impact of their clinical work. This might support them to prevent burnout especially since the various dynamics present in systemic work are more demanding than work with individuals. In this way, findings of such research might act as a buffer and a preventative measure by increasing awareness of what might burden therapists and eventually lead them to burnout.
It might also be worth mentioning that participants illustrated how their personal experiences might be linked to their choice of therapeutic career. Metcalf (2011) explains that clients experience authenticity when they are offered the opportunity to be accompanied on their therapeutic journey by a therapist that chose a therapeutic modality that resonates with his or her life perspective.

Thus future research that explores further this connection between the personal experiences of family therapists and their choice of therapeutic modality might support further interest and reflections on therapists’ authenticity. This could be of benefit to therapists and families alike.

### 6.6 Conclusion

As I reflect on my process and learnings around connection and change at the end of this complex research journey, I am now inclined to think of striking moments of connection with clients as being rather like the ebb and flow of the tide. As a therapist, you are aware of their existence, but you have to wait for them, and then gracefully slip into the sea of co-creation that occurs between you and your client/s.

If you succumb to these moments, and you embrace them, free of fear and insecurity, your curiosity around these special instances of intimacy may keep their integrity and therapeutic potential alive. If you as therapist, willingly yield to these wondrous moments, in doing so, the client bestows on you a glimpse of what it means to be human, and offers you little glimmers of hope that lay suspended between you both full of opportunities of transformation and healing. As a therapist, I feel privileged to have found my place of safe connection, and I hope to extend my hand to my clinical families and ask them to accompany me along our mutual path of enlightenment, connection and change.
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Appendix A

RECRUITMENT LETTER TO PROFESSIONALS.

Dear Sir/Madam,

I hope this finds you well.

My name is Tanya Carmen Chetcuti holder of (British Passport no 801118960) and I am currently in my second year of studies reading for a Masters in Systemic Psychotherapy at the Institute of Family Therapy Malta.

As part of my studies, I will be conducting a research project that aims to address the topic of striking moments in the therapeutic relationship from a systemic therapist perspective, under the supervision of Mr. Joe Mangion.

This aspect of the therapeutic relationship is significantly an under-researched one in Malta and to some extent, also within the Anglo-American body of literature. Therefore, any research findings in this area are pertinent and timely.

This study seeks to provide a deeper understanding of how these moments of connection that we share with clients are forged with and in the dialogic therapeutic relationship and how this may ameliorate or contribute towards the process of change in therapy.

I am humbly requesting your cooperation to consider participating in this research. This research shall take the form of a qualitative interpretive phenomenological analysis and semi-structured interviews will be administered to six systemically trained professionals. Should this be possible, interviews shall be held with selected candidates who are systemically trained and practicing psychotherapists as the sample criteria requires that as a participant you are a fully qualified and practicing systemic psychotherapist.
During this process all the necessary safeguards will be in place to protect confidentiality and to ensure that participants are not harmed in any way. The data will be destroyed accordingly after the research process is concluded.

Also, at the end of the data collection process, you will be given feedback on the outcome of the interviews, and if any difficulties take place during the research process you will be referred for further support if the need arises.

The results from the interviews will be compared with any other literature findings on the topic of research.

The results will be presented in a Dissertation that will be submitted in partial fulfilment of the requirements for the Degree of Masters in Systemic Psychotherapy with the Institute of Family Therapy Malta.

I would like to take this opportunity in advance to thank you for your time and I look forward to hearing from you in this regard should you think that you can be of support to the above indicated research.

Kind regards,

Tanya Carmen Chetcuti.

Masters in Systemic Psychotherapy student.

Institute of Family Therapy Malta.
Appendix B

Consent Form

Title of research project: Striking moments in dialogic exchanges from a systemic therapist perspective

Researcher: Tanya Carmen Chetcuti.

Thank you for agreeing to take part in this research. In agreeing to participate, you have the following rights and protections as laid down by the IFT-Malta ethical board which is in accordance with the British Psychological Society’s Ethical Guidelines.

1. Your participation is entirely voluntary.
2. Under no circumstances will your real names or identifying information be included in the reporting of this research.
3. You may withdraw your data from this research at any point up to data analysis.
4. Nobody accept myself, my research supervisor, or any external examiner will have access to this anonymized material.

In agreeing to the terms of this consent form, participants should be aware that any anonymized material is solely for use in the current research projects.

I confirm that I have read and understood the information sheet dated January 2015 for the above study and have the opportunity to ask questions

☐

I understand that my participation is voluntary and that I am free to withdraw at any time, up to the point of data analysis, without giving any reason.

☐

I give permission for the researcher to audio tape-record all interviews that I give

☐

I give permission for the researcher to transcribe the interviews keeping my identity anonymous

☐

I agree to take part in the above study

☐

Name of Participant: ________________

Signature: ________________ Date: ________________

Name of Researcher: ________________

Signature: ________________ Date: ________________
Appendix C

Research Interview Schedule

1. Do you think that as a therapist you experience relational connection with your clients?
2. If so, do you think that the personhood of the therapist influences this phenomenon in any way?
3. What are the moments when you feel most connected to your clients, perhaps you can share an example?
4. How do therapists and clients experience connection, is it the same?
5. Do therapists who value and invest more in the therapeutic relationship experience these moments of connection with clients more?
6. What is your epistemology as a therapist? Can you define this?
7. How has your epistemological stance as a therapist influenced your beliefs about change?
8. What schools influence your way of being professionally?
9. If you could use a metaphor to describe your preferred therapeutic style what would that be?
10. What do you think your clients would say about your therapeutic style if they could describe it?
## Appendix D

<table>
<thead>
<tr>
<th>Emergent Themes</th>
<th>Original Script</th>
<th>Exploratory Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Connection seen as primarily human endeavour.</strong></td>
<td>Interviewer: OK, this is interview number 3. Good afternoon.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Participant: Good afternoon.</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Interviewer: I'm going to ask you a few questions, so the first question is, do you think that as a therapist you experience relational connection with your clients?</td>
<td></td>
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<tr>
<td></td>
<td>Participant: Yes I think so, I think that usually I mean in the beginning or maybe by the third session I think or maybe fourth session you know as the therapy progresses I think yes I am, you know I care for them I find myself caring for them, thinking about them so it is a connection between one human being to another and that's how I see you know my work to be and I know that kind of what's going to affect change is the relationship, is the connection and I do genuinely feel connected to them obviously in a different way than for example I feel connected to a friend but I feel I care for them, I keep them in mind as I said before. In Maltese we have a saying like 'irridulhom il-ġid' so it's like you know you want them to do well in life and I guess I appreciate the</td>
<td><strong>Theme of engagement as an involuntary connective being with process.</strong></td>
</tr>
<tr>
<td><strong>Connection seems to occur involuntarily, without effort, resulting from exposure to client/s.</strong></td>
<td></td>
<td><strong>A firstly human endeavour, reaction and connection</strong></td>
</tr>
<tr>
<td></td>
<td></td>
<td><em>&quot;I find myself caring for them, thinking about them so it is a connection between one human being to another and that's how I see you know my work to be</em>&quot;</td>
</tr>
<tr>
<td><strong>Connection with clients seen to be different yet the same as with friends.</strong></td>
<td></td>
<td><em>&quot;I know that kind of what's going to affect change is the relationship, is the connection and I do genuinely feel connected to them obviously in a different way than for example I feel connected to a friend but I feel I care for them, I keep them in mind as I said before. In Maltese we have a saying like 'irridulhom il-ġid' so it's like you know you want them to do well in life and I guess I appreciate the</em>&quot;</td>
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