Shared Sequences from Network Therapy with Adolescents Only the therapist Finds Meaningful

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As part of a larger research project, this qualitative study explores sequences from six network therapy sessions. We focused on these sequences because only the therapists found them to be meaningful; the other participants did not think they were significant. The aim of this study was to explore the therapists' inner dialogues, the degree to which these inner dialogues consist of professional and personal voices, and what this means for the dialogical process. We used a multi-perspective methodology that combines video recordings of network therapy sessions, participants' interviews, and text analysis. We found that the outer dialogue and the therapists' inner dialogues are strongly related to each other and that both personal experiences and professional knowledge are present in an implicit way, which helps the therapist to be present in the dialogical process both as a person and as a professional. We also found that when the outer dialogue is very emotional, the therapist moves away from the outer dialogue and becomes more present in their inner dialogues.

Keywords: network therapy, dialogical practice, inner and outer dialogues, dialogical process

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Key Points

1 The interplay between inner and outer dialogues is central when meaningful sequences of the therapeutic conversation emerge.
2 The therapists' inner professional dialogues are present in an implicit way, adapted to the outer dialogue.
3 The presence of both professional and personal voices gives life to the outer dialogue and helps the therapist to be present in the dialogical process.
4 When the outer dialogue is highly emotional, the therapists' inner dialogues are dominated by personal voices and the professional voices recede.
5 The relationship between the therapists' inner professional and personal dialogues helps the therapist to achieve a professional understanding of and give life to the outer dialogue by being present in the actual conversation.

This study is part of a research program titled 'Dialogical collaboration in southern Norway,' which focuses on a variety of dialogical approaches and practices in health care systems in southern Norway. The aim of this study was to use a dialogic perspective to explore what happens when therapists find sequences in therapy sessions to be meaningful but do not say anything about it in the session. By including the

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therapists' inner dialogues from those sequences, we hoped to gain more knowledge about (and insight into) what occurs in these situations and how they emerge.

Any form of psychotherapy consists of a multitude of overt and covert processes. In addition to the visible and audible aspects of therapeutic conversations, we know that therapeutic meetings feature covert dimensions that have an important role in the therapeutic process (Andersen, 1994; Anderson & Goolishian, 1992; Lidbom et al., 2014, 2015; Rober et al., 2008). We know that clients and therapists differ with respect to which aspects of therapeutic conversations they find to be significant or meaningful (Gerhart-Brooks & Lyle, 1999; Llewelyn, 1988; Timulak, 2010). From one point of view, we may say that clients are focused on receiving help with their problems and hope that therapy will give them a feeling of support and relief (Llewelyn, 1988; Timulak, 2010), whereas therapists emphasise qualities such as insight, self-awareness, and other professional concepts.

A dialogical approach to family and network therapy focuses on both the overt and covert processes in the therapeutic meeting. Therapy is seen as involving a multiplicity of voices, speaking to the addressee from different positions and often in dialogue with each other (Bakhtin, 1984; Olson, Laitila, Rober, & Seikkula, 2012). This is true of both the outer dialogue and the various participants' inner dialogues. From a dialogical perspective, we can ask whether the healing element in the coevolving therapeutic process can be found in the articulation of experiences that have yet to be voiced. (Anderson, 1997; Seikkula & Trimble, 2005). This is a process that makes the presence of a polyphony of inner and outer dialogues essential, because it gives access to new perspectives, words, and meanings (Lidbom et al., 2014, 2015).

The therapists' inner dialogues

In therapeutic conversations, therapists often ask themselves, 'What shall I say?,' 'What words can I use here?,' 'What do they expect from me?,' and so on. Usually these and similar questions are not asked from an explicit theoretical or professional position; they are voiced from a personal position (Rober, Larner, & Paré, 2004). Co-evolving therapeutic conversations involve an interplay between several different dialogues occurring at the same time. In this therapeutic context, we can ask whether there are similarities and differences between the therapist and the other participants. One of the major similarities between the therapist, the client, and his/her network of family and significant others is that they are all present as living persons, with their own personal histories and experiences. One of the major differences is that the therapist is a professional who uses theories and methods as a guiding framework for how he/she understands the co-evolving process of talking together. Rober et al. (2008) describe therapists' inner dialogues as inner 'positions' embodied as voices in dialogue with each other. They suggest that a therapist's inner dialogues move between four positions, each of which is a concern of the therapist. (1) *Attending to the client's process* refers to the therapist's effort to connect with and focus on the client's personal process in the here and now of the session. The attention is on the client. (2) *Processing the client's story* refers to the therapist's internal processing of the content of the client's story about 'there and then,' the world outside the session. (3) *Focusing on the therapist's own experience* concerns the therapist as a living, experiencing human being and refers to his/her reflections and self-talk in the 'here and now' of the session. (4) *Managing the therapeutic process*

concerns the therapist's managing the process given his/her responsibility as a therapist: taking care of the therapeutic context, assisting the client in the telling of his/her story, and reflecting on the therapeutic attitude. The therapist is focused on what he/she can do to help the client.

The main focus in three of Rober et al. (2008) positions is on the professional voices and dialogues (*Attending to the client's process, Processing the client's story,* and *Managing the therapeutic process),* with the fourth position focused on personal voices (*Focusing on the therapist's own experience).*

Significant and meaningful moments in a therapeutic conversation

Research on significant and meaningful moments in therapy explores and analyses shorter episodes of the therapeutic process (Greenberg, 2007; Timulak, 2010). The underlying rationale is that these events are the most helpful sequences (or problematic points) in the therapeutic process (Timulak, 2010). Most of this research has been done in individual therapy; research on family and network therapy is very limited. The types of family and network therapies that focus on generating dialogues entail not only focusing on the content of narratives, but also unfolding feelings and experiences in the moments when the narratives are told (Seikkula, 2008, 2011). Through this process, an intersubjective consciousness emerges that involves real contact between the people participating in the dialogue. In every meeting, two histories occur. The first history is generated by our presence. We adapt ourselves to each other and create a multi-voiced, polyphonic experience of the shared event, and most of this adaption happens almost without words. The second history occurs in the participants' stories from their lives. These stories refer to the past; they can never reach the present moment, because when a word is formulated, and when it is heard, the situation to which it refers has already passed (Seikkula, Laitila, & Rober, 2012). With these two histories in the same moment, the therapists shift their position from being interventionists with planned actions to focusing on their response to the clients' utterances, as their answers are the 'generators' for mobilising the client's own resources (Seikkula et al., 2012).

Therefore, significant and meaningful moments in the conversation cannot be planned. They will emerge in the conversation at various times and with different content for the respective participants, and both the timing and content of these occurrences will play an important role in what is and is not uttered in the conversation. Through this process, experiences that have not been articulated nevertheless find their expression in the therapeutic conversation (Lidbom et al., 2014). In earlier research (Lidbom et al., 2014, 2015), we have shown that significant and meaningful sequences shared between the therapists and the other participants in therapy are strongly related to the interplay between the outer dialogue and the participants' inner dialogues. In those sequences, the inner dialogues contribute to a diversity of perspectives, experiences, and meanings by their movements in time and between the two positions of reflection and presence. This diversity represented by the polyphony, makes it possible for the participants to place themselves in the ongoing conversation as living persons. As an example of those movements and the emerging polyphony, we can imagine a situation where the adolescent starts to weep in the middle of the network meeting. The therapist becomes unsecure of how he/she shall handle this, and starts to reflect upon different possibilities: *Shall*

I act like a professional, a parent, or just as a fellow human? The therapist ends up comforting the adolescent.

In dialogical theory and practice, our knowledge of the interplay between the outer dialogue and the participants' inner dialogues play an important role in our understanding of therapeutic conversations and processes (Olson et al., 2012; Rober et al., 2008; Seikkula, 2002). As the professional and in many ways the party responsible for the therapeutic process, the therapist plays an important role, and because of that he/she may have a different perspective with different themes compared with the other participants. With that in mind, we attempt to answer the following questions in this article:

- What is the relationship between professional and personal knowledge in the therapists' inner dialogues?
- What is the meaning of those inner dialogues for the dialogical process?

Method

This study and the cases presented in this article are part of a larger research project titled 'Network meetings: A meeting on the border between outer and inner dialogues.' This is a qualitative study of adolescents aged from 16 to 18 years of age who are in mental health crisis, seeking help from the mental health care system for the first time, and receiving network–oriented help. These adolescents were referred to the mental health care system by their general practitioners. The adolescents, members of their networks, and the therapists all voluntarily participated in this research. Another study followed the same adolescents and explored their experiences of change related to both the network therapy and their lives in other social arenas important to them (Bøe et al., 2013, 2014, 2015).

In this study, we investigated one network therapy session for each of the six adolescents who participated. Members of the adolescents' networks attended these sessions, as did one (one case) or two (five cases) network therapists. Each of the participants had at least two therapy sessions before we filmed for this study. We developed the data collection method based on a method used by Rober et al. (2008), in which the researcher filmed the therapeutic conversation and then interviewed the participants within 4 days of the session. By filming the interviews we obtained access both to the facial expressions and gesticulations of those who were interviewed. The first stage was taking a video recording of one therapy session. In the second stage, the researcher interviewed each participant separately within 4 days of the therapy session. During this interview, each person watched the entire recorded therapy session on a computer screen without pausing. Immediately thereafter, they watched the session again with the instruction to stop the video when they saw something significant or meaningful happening. When they stopped the video, the researcher asked each of them the same initial question: 'What went through your mind right there?' This question was intended to elicit some of the inner dialogues he/she had during the highlighted sequences. No other questions were prepared for these interviews. We attempted to make the interviews similar to a dialogical conversation, in which the researcher focused on listening and responding to the participants' utterances.

The interviews were filmed, and the third stage of the method was to transcribe the therapy sessions and the interviews for analysis and interpretation. In the fourth stage, we combined the transcriptions of each participant's therapy session and the associated interviews to provide an overview of the whole therapy session. The content of the outer dialogue was juxtaposed with that of each participant's inner dialogues at the points in the outer dialogue at which each participant indicated a significant or meaningful moment. Based on this information, we were able to identify those sequences during the sessions that the therapist found significant but the other participants did not. Those sequences were then analysed.

We used a hermeneutic phenomenological approach, Systematic Text Condensation (STC), to analyze the content of the outer and inner dialogues and the interplay between them (Graneheim & Lundman, 2004; Malterud, 1993, 2013). Systematic Text Condensation is a method inspired by Giorgio's phenomenological analysis (Giorgio, 2009, 1985), and Grounded Theory (Glaser, 2001; Glaser & Strauss, 1967). This approach allowed us to interpret and recontextualise the participants' experiences in a way that laid the foundation for new descriptions that could be useful for therapeutic knowledge, while remaining loyal to the participants' voices and dialogues. In this analysing process we also used the model of Rober et al. (2008). A preliminary analysis took place, first by the first author and then discussed in the research group. This mixture of group and individual work took place through the whole analysis process. We were unable to obtain the exact content of the participants' inner dialogues at the moment they occurred; however, a combination of direct observation, interviews, and analysis allowed us to come as close as possible to describing them relevant to our specific concerns.

We informed the participants of the potential for adverse reactions to being filmed, and we solicited their consent after we informed them about the implications of participating in this study. This study was approved by the National Committee for Medical and Health Research Ethics.

The cases

Six adolescents (and the chosen members of their network) participated in this study. Two of the adolescents were boys and four were girls. Table 1 presents an overview of the study.

Results of Analysis and the Chosen Sequences

In the six network therapy sessions, there were 35 conversation sequences that one or both therapists experienced as significant or meaningful (for the distribution of these sequences between six different therapy sessions, see Table 1). In this context, a significant or meaningful moment does not necessarily indicate a purely positive or good moment; it only indicates that the therapist experienced what was happening in the outer dialogue as significant and/or meaningful in one way or another.

The most common positions in the therapists' inner dialogues were, *Processing the clients story* and *Focusing on the therapist's own experience.* In every sequence except one, the therapists' inner dialogues exhibited two or more positions. The outer dialogue in the sequence with one position was actually a therapist's monologue, and the same therapist recalled an inner voice that was speaking from a single position (*managing the therapeutic process*). Generally, we also found that when the outer

TABLE 1
Current Information about the Cases in This Study

Case number	Reason for referral	Duration of the therapy session	Number of significant, meaningful sequences	Participants in the therapy session
Adolescent 1	Depression, anxiety, and suspected psychosis	1 hour 15 minutes	4	Two therapists (male and female), the adolescent, and his mother
Adolescent 2	Depression, anxiety and suspected serious mental illness	54 minutes	2	Two therapists (male and female), the adolescent, and her mother
Adolescent 3	Depression and complicated grief process	1 hour 15 minutes	9	Two therapists (two females), the adolescent, and her aunt
Adolescent 4	Anxiety	45 minutes	5	One therapist (male), the adolescent, and his father
Adolescent 5	Depression and suspected serious mental illness	1 hour 10 minutes	9	Two therapists (male and female), the adolescent, and her mother
Adolescent 6	Trauma after rape	1 hour 10 minutes	6	Two therapists (two females), the adolescent, and her friend

The reason for referral column refers to the network therapists' estimations after the previous meetings and is not based on a diagnostic process.

dialogue becomes emotional, the therapists' inner dialogues were dominated by the *Focusing on the therapist's own experience* position. Examples of this occurred in the conversation with adolescent 6, in which the outer dialogue was strongly focused on the different traumatic experiences of the participant when she was raped, and the conversation became very emotional.

Of the two positions that dominated the therapists' inner dialogues, *Processing the clients story* was represented 38 times and in 25 of the 35 sequences, and *Focusing on the therapist's own experience* was represented 37 times and in 24 of the 35 sequences. In the two examples below, you can see some of the therapists' inner dialogues. In the first example, the therapists' inner dialogues are dominated by the *Attending to the client's process* position, and in the second example, the therapist's inner dialogue is dominated by the *Focusing on the therapist's own experience* position.

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Example 1 (Attending to the client's process): With adolescent 3, where the outer dialogue is about how the adolescent coped with her life after her mother died.

Therapist 1		Therapist 2		The adolescent		The aunt	
Inner D	Outer D	Inner D	Outer D	Inner D	Outer D	Inner D	Outer D
What the aunt is saying is important, and it's different from what she said before. She confirms that the girl has it difficult. I hope she understands June better now.	Yes.	*The aunt is giving an aptly good description how June is doing. The aunt described it better than how she described it earlier; a more balanced description. I hope that June is noticing this.*	Mmm. Mmm.				When adults go through the same difficulties they will go on sick leave, but adolescents can't do that. But adolescents have to handle school, friends, and things like that. What has become better for her is that she is closer to her friends.

In this example, both of the therapists had an inner dialogue on how the aunt was describing the adolescent's situation, and they both regarded the description as balanced and apt, in that it confirmed the difficulty in the adolescent's life.

Example 2 (Processing the therapist's own experience): With adolescent 6. The outer dialogue is focusing on what happened just before she got raped.

Therapist 1		Therapist 2		The adolescent		Female friend	
Inner D	Outer D	Inner D	Outer D	Inner D	Outer D	Inner D	Outer D
Now (the name of therapist 2) is active. It's good for the conversation.			Mmm. Mmm. Yes. You tried to check it out and		I noticed after I inhaled a few times that I got dizzy. I asked if they would have		Mmm.

(continued)

Example 2   *(continued)*

Therapist 1		Therapist 2		The adolescent		Female friend	
Inner D	Outer D	Inner D	Outer D	Inner D	Outer D	Inner D	Outer D
I've got this feeling of running empty, a feeling of emptiness and paralysis.			then you were received? Yes.		some, but they said they already had been smoking. And that told me there was something in that joint that they wouldn't smoke. Yes. Yes … mmm. I thought it was common hashish.		

In this example, the therapist's inner dialogue is between voices from two positions. It begins with a voice speaking from the *Managing the therapeutic process* position, and then it is dominated by a voice speaking from the position of *Focusing on the therapist's own experiences.*

We also found that we could identify professional voices in professional positions (*Attending to the client's process, Managing the therapeutic context*, and *Processing the client's story*) that were not necessarily explicit in their professionalism. In these instances, the voices did not express professional concepts; instead, they were more directed to the situation and the themes in the outer dialogues. In the therapists' inner dialogues that were dominated by professional positions (especially the positions of *Attending to client's Process* and *Processing the client's story*), the inner dialogue often began with a question and ended with a presumed answer to the question, as in the next example. The following example occurred in the conversation with adolescent 4, and the therapist's inner dialogue emerged while they were talking about the adolescent's high score on the ORS - schema[1]:

> *He has a need to come here and talk with me, but what is it he wants? I think we are together here because he dreads autumn and school.*

Most of the questions the therapists asked themselves in their inner dialogues remained as inner dialogues and were not articulated during the session. Rather than asking the adolescent these questions, the therapists answered most of their questions with assumptions, as in the example above.

The two positions that were represented the fewest times in the therapists' inner dialogues were *Managing the therapeutic process* (represented 27 times in 23 of 35 sequences) and *Attending to the client's process* (represented 27 times in 20 of 35 sequences). Both of these positions are professional positions.

In many ways, these results are similar to what we found in our earlier studies (Lidbom et al., 2014, 2015), with a strong connection between the outer and inner dialogues representing different positions that yield useful perspectives on the themes in the outer dialogue, and the importance of the polyphony of voices present in both the outer and inner dialogues. What is new in this study is how implicit the presence of personal experiences and professional knowledge appear to be, and how adapted the words and the phrases applied in the therapists inner dialogues are to the outer dialogue. The therapists' professional and personal inner dialogues become a part of the emerging polyphony, not in the sense that they are uttered, but in that they still have an important impact on what is being uttered and not.

Discussion

All of the inner dialogues but one in this study involved two or more voices speaking from two or more positions. We know that inner dialogues consist of different positions in which each voice expresses something relevant and significant from its perspective (Rober, 2005a; Rober et al., 2008; Seikkula, 2008). One or several professional voices were present in the therapists' inner dialogues in all of the 35 sequences we studied, whereas only 24 of the 35 sequences had voices speaking from a personal position.

We found it interesting to observe how professional knowledge was present in the therapists' inner dialogues and how this knowledge was adapted to the outer dialogues. Professional knowledge tended to be implicitly represented in the therapists' inner dialogues. Very few of the therapists' inner dialogues were formed as theoretical statements, and they contained very few explicit words or phrases taken from the theoretical world. Almost all of the inner dialogues used words that addressed the actual sequence of the outer dialogue. This can be seen to indicate that professional knowledge is not necessarily explicit in meaningful, significant moments; instead, it is more implicit, used in a transformed way by the therapist and adapted to the specific context, persons present, themes, and words of the outer dialogue (Rober et al., 2004; Seikkula, 2008; Stern et al., 1998). When therapists adapt and transform professional knowledge in this way, even when they are unaware of what they are doing, the other participants in the therapy session are likely to regard their utterances as a natural part of the conversation.

This view of professional knowledge can be compared to how knowledge is understood in the concept of the 'not knowing' position (Goolishian & Anderson, 1992; Rober, 2005b; Anderson, 2012), in which knowledge refers to 'knowing with' the client, a type of knowledge that is crucial to the dialogical process (Anderson, 2012). When a therapist is in a therapeutic conversation with clients, the therapist's inner dialogues are understood to emerge from the interplay between all the participants in the network therapy session. Thus, the therapist's inner dialogues do not belong solely to the therapist; they belong to each participant in the therapeutic session (Bakhtin, 1986; Rober et al., 2004). The therapist's inner dialogues are not entirely created in the therapist's mind; they are related to the outer dialogue and created by all of the participants

in the therapeutic meeting. From this perspective, we can see that there is a strong relationship between the outer dialogue and the therapist's inner dialogue and professional knowledge during sequences that the therapist experiences as significant or meaningful. The outer and inner dialogues seem to represent several different viewpoints of the ongoing interaction during significant meaningful moments (Lidbom et al., 2014).

The *Focusing on the therapist's own experiences* position was represented 37 times and in 24 of the 35 sequences we studied. The majority of these sequences were related to the here and now situation, as shown in Example 2, while at the same time being in some way related to the therapist's narratives that were not explicitly uttered. From a dialogical perspective, Shotter (1993) uses the concept of 'witness,' which refers to being spontaneously responsive to another person during the unfolding events of a therapeutic meeting. To be in a 'witness' relationship means that the therapist is trying to be attuned to her/himself and to the other people in the conversation. This allows the therapist to access his/her own experiences in a way that is relevant to the sequence of the conversation (Errington, 2015; Rober et al., 2004). This can include incidents from the therapist's own narratives that are not necessarily explicit or present in his/her inner dialogues.

In much of the material from our research, the feelings that are evoked by the outer dialogue become prominent and the narratives related to these feelings remains in the shadows. Which narratives and experiences are activated in the conversation is related to the people who are present, the themes and words uttered in the outer dialogue, and the context in which the conversation takes place. In this sense, much of what happens in the outer dialogue and the therapist's inner dialogues is strongly related, albeit not necessarily in an explicit way with respect to the therapist's own experiences; what are explicit are the feelings evoked by the outer dialogue.

Therapists' professional knowledge and personal experiences are both essential influences on what they experience as significant or meaningful in therapeutic conversations. When professional knowledge and personal experiences are both present in inner dialogues, they give life and meaning to the other participants' utterances and thereby enable us as therapists to derive meaning and make assumptions about what is going on in the outer dialogue. Together, these professional and personal positions appear more as implicit knowledge and experiences than as explicit objects (Stern et al., 1998; Stern, 2004; Seikkula, 2008). We also found that the therapists' inner dialogues were always related to the outer dialogue, and that the inner dialogues were more likely to be adapted to the outer dialogue than the other way around. All of this can be understood by the term 'being present' in the conversation (Stern et al., 1998; Rober, 2005a,b; Seikkula, 2008). As therapists, the presence of both professional and personal voices in dialogue with each other helps us give life to our own and the other participants' utterances, which, in turn, enables us to find meaning and make assumptions about the outer dialogue – from both personal and professional positions. Our tentative hypothesis is that the inner dialogues between the personal and professional positions and voices have an impact on what has been described as the therapist's 'personal style' of doing therapy. By emphasising the therapist's inner dialogues, we focus on the therapist's personal history and the theoretical references evoked by the actual therapy session and its emerging outer dialogue. Thus, by focusing on the outer dialogue that way, the inner dialogue of the other participants present in the actual meeting has an impact on the therapist's inner dialogues through their relation to the outer dialogue.

Bateson (1972) described what he called the relational mind as an active entity that is formed from all of the participants; a mind that changes along with the outer dialogue, the interlocutors' inner dialogues, and their physical responses (Bateson, 1972, 1979). Our study shows how this happens when we are in a dialogical process, a process that is never complete or fully under our control because it emerges in a spontaneous, subjective, and implicit way (Cunliffe, 2002; Shotter, 1993, 1997). This can be related to what Shotter (1993) calls 'knowing from within,' in which we are continually being re-constructed and updated in unique relational moments and acts of being; it is a way of being present that differs from a disembodied, professional-knowledge way of being. In all of our sequences except one (with adolescent 2), we found that the therapists' inner dialogues were strongly related to the outer dialogue, and to the therapists' implicit knowledge, and this relationship helped the therapists to be present in the conversation; in other words, to be in the dialogical process. What the therapist should be aware of is when the outer dialogue contains themes with high emotional intensity, like rape or bullying, it is more likely that the personal voices become dominating in the therapists' inner dialogues. This may influence the therapist to leave the outer dialogue to stay in his/her inner dialogues and thereby fail to be present sufficiently to respond to the other participants' utterances (Lidbom et al., 2015). We have no basis to say whether this affects the dialogical process in a positive or negative way, because in some way the polyphony of the outer dialogue and the inner dialogues may be helpful. At the same time, however it can divert the therapist's attention away from the outer dialogue and prevent him/her from responding appropriately to utterances in the outer dialogue.

Conclusion

This study has shown that the sequence of therapeutic conversations that therapists find significant or meaningful are mainly about the outer dialogue, the therapist's inner dialogues, and the different positions their inner voices speak from, and the interplay between those different units. The therapists' inner dialogues consist of voices speaking both from professional and personal positions. The contribution of professional knowledge appears to be more implicit than explicit, because it is transformed and adapted to the context, persons, themes, and words in the outer dialogue. This transformation of knowledge seems to be important because it helps the therapist to give meaning to what is being said and to make assumptions about how the different utterances can be understood from different professional positions. Most of the sequences the therapists identified as meaningful were dominated by the professional voice, and by this we can assume that there is a strong connection between the therapists' experience of significant/meaningful moments and their disciplinarity. In addition, the personal voices in the therapists' inner dialogues were important because they helped the therapists be attuned to their experiences while at the same time remaining present both as a person and as a professional in the dialogical process. This helps the therapist give life and a personal meaning to what is being said. We also found that when the outer dialogue is emotionally intense therapists should realise how this moves the therapist away from the outer dialogue into his/her inner dialogues, which may come at the expense of being present and sufficiently responsive to what is being said in the outer dialogue.

This study also shows that the relation between the therapist's professional and personal inner dialogues helps him/her to create a professional understanding of the

outer dialogue while maintaining the personal voices and dialogues needed to remain present in the conversation and thereby give life to the outer dialogue.

Note

1   The ORS (Outcome Rating Scale) is a feedback schema developed by Scott Miller and Barry Duncan (Miller and Duncan, 2000). It is administered at the beginning of each session and provides the clinician with information that can help to determine whether the therapy is on track.

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