Research and Practice: A Reflexive and Recursive Relationship– Three Narratives, Five Voices

Jerry Gale
Ronald Chenail
Wendy L. Watson
Lorraine M. Wright
Janice M. Bell

SUMMARY. In this multiply-authored account, five academicians discuss the connections between their work as clinicians and their clinical qualitative research. Each saw connections between practice and research, and each in her or his own domain of interest has found that practice informs research and research informs practice. This article also introduces three major types of qualitative clinical family research: conversational analysis, recursive frame analysis, and hermeneutic phenomenology. *[Article copies available for a fee from The Haworth Document Delivery Service: 1-800-342-9678. E-mail address: getinfo@haworth.com]*

Jerry Gale is Associate Professor, Department of Child and Family Development, The University of Georgia, Athens, GA 30602. Ronald Chenail is Dean, School of Social and Systemic Studies, Nova Southeastern University, Fort Lauderdale, FL 33314. Wendy L. Watson is Associate Professor, Marriage and Family Therapy Graduate Programs, Brigham Young University, Provo, UT 84602. Lorraine M. Wright is Director, Family Nursing Unit, Department of Family Sciences, and Professor, Faculty of Nursing, University of Calgary, Alberta, Canada T1Y 6J4. Janice M. Bell is Research Coordinator, Family Nursing Unit, and Associate Professor, Faculty of Nursing, University of Calgary, Alberta, Canada T1Y 6J4.

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To write this paper, the first author contacted the other four authors about a collaborative piece regarding their experiences connecting practice and research. Each author began his/her professional career as a practitioner. While each of the following stories stands on its own, together they weave a broader narrative. The first piece presents a practitioner's development from a family therapist to a therapist/researcher and his discovery that research and practice could recursively inform one another. The second piece describes how a family therapist/researcher uses Recursive Frame Analysis to track the process of change in conversations. Specific examples are given of how this knowledge allows him to be a reflective discourse analyst while simultaneously conducting therapy. The third story tells how two nurse practitioners and a family therapist employed hermeneutic inquiry to generate new discoveries and insights of their clinical practices and a passion for working as a clinical research team.

A PRACTITIONER'S ENTRY INTO RESEARCH
JERRY GALE

In 1986, following many discussions with my wife, we decided it would be valuable for me to receive a PhD. Having worked in a number of clinical settings (e.g., group homes, foster homes, juvenile courts, community based programs and private practice) for the previous ten years, we agreed that a doctorate would improve my clinical abilities as well as increase my earning potential. At that time, I had a master's in guidance and counseling (1979) which provided me with minimal background in research. Through workshops, seminars and supervision, I had a lot of clinical training in family therapy and Ericksonian hypnosis.

Upon entering the Department of Human Development and Family Studies at Texas Tech University, specializing in marital and family therapy, my identity-story was dominated by an emphasis towards clinical practice. Though a therapist and not a researcher, I was interested in investigating the communication aspects of the therapeutic process. My curiosity about communication processes developed primarily out of early childhood experiences with a speech impediment (Gale, 1991b) and my post-graduate training in Ericksonian psychotherapy, with its emphasis on language and relationships.

Studying Clinical Communication

While at Texas Tech, I enrolled in a number of courses that fueled my interests in studying clinical communication. One course was an introduction to ethnography (taught in my home department of human development and family studies). Additionally, courses taught by Brad Keeney, and lectures from visiting faculty (e.g., Heinz von Foerester, Stephen Tyler and Harry Goolishian) stimulated my interest in theoretical aspects of communication (second order cybernetics, linguistic systems and constructivism).

These classes and lectures nurtured a respect and appreciation for qualitative methods. I became very interested in studying methods and procedures for gathering and analyzing phenomenological experiences. This quest and interest in communication led me to take classes in the Department of Speech Communication. In my second year in the program I participated in a study interviewing families receiving care from pediatric cardiologists at the University Hospital (Chenail, Douthit, Gale, Stormberg, Morris, Park, Sridaromont, & Schmer, 1990). This project entailed interviewing families, and introduced me to data collection, data immersion, transcribing, category development via discourse analysis, collaborating with colleagues, the rigors and commitment of time of doing qualitative research and the excitement of writing and publication. In order to learn how to carry out this research, four of us took a directed readings class with G. H. Morris in the department of speech communication.

From this project, I developed an appreciation for the rich, thick landscape of the interviewees' descriptions. As a practitioner, I had valued and used clients' detailed stories. However, the interviewing component of the pediatric family study suggested that there was more to listening than I had previously suspected. The family interviews further highlighted for me how narratives are co-constructed through the participation of many (family and community members) and the power that these stories had to impact health.

Performative Aspects of Language

As I approached my dissertation, my research and theoretic paradigm was shifting toward the performative aspects of language (Austin, 1962; Potter & Wetherell, 1987), and tracking the therapeutic conversation. That is, how verbal and non-verbal interactive processes themselves are practical activities that create and maintain social realities. These ideas were impacting my clinical practice! I was more attentive and sensitive to the micro-communication practices of the clients and myself. It was useful to

consider how the verbal and non-verbal interactive processes themselves are practical activities that create and maintain social realities. At this time, it made sense to me that qualitative methods were appropriate for addressing these issues. Further, the qualitative literature that I was reading (conversation and discourse analysis, ethnomethodology and marital and family therapy process research) informed and enhanced my clinical skills as well as my instructional skills. I was becoming a better listener and a better communicator as well as developing an understanding of how knowledge is actively constructed. My research pursuits were positively impacting my clinical skills! My prospectus proposed doing a conversation analysis of a marital therapy case.

Obtaining a videotape of a single session consultation conducted by Bill O'Hanlon (internationally acknowledged as a master clinician of solution focused therapy, see O'Hanlon & Weiner-Davis, 1989), I made an audio-tape and transcribed the session. I spent about 80 hours viewing the videotape and listening to the audio-tape. I developed nine themes through the iterative processes of transcribing, developing categories and conducting constant comparative analysis (Gale, 1991a; Gale & Newfield, 1992). While the analysis focused on the collaborative communication of the therapist and couple, the themes developed highlighted the rhetorical procedures used by the therapist.

Doing the Dissertation

Doing the dissertation, which captured my attention and passion, was also a tedious and frustrating process. Many times I experienced doubts about my abilities to complete the project. (I questioned if I was really a researcher, and I struggled to see the data from different perspectives.) It was only through many discussions and support from faculty, colleagues, other researchers, and my wife, that I persevered.

This study greatly affected my clinical and research practice, and it contributed to a deeper understanding of conversations as both social and constructive phenomena. The powerful relevance of micro-details of talk also became apparent. From a clinical perspective, this awareness increased my sensitivity to the non-verbal and verbal exchanges between myself and clients. Analyzing the rhetorical skills used by the therapist in my study pointed to a sophistication of communication practices that had heuristic value (Gale, 1991a; Gale & Newfield, 1992) and have since affected my teaching practices as well. This knowledge supported a respect for the politics of talk that occurs at the micro-level. This challenged my previous

view of therapist neutrality, and contributed to the pursuit of collaborate relationships between myself and client/research participants.

Unexpected Shifts in Identity-Story

My activities in graduate school, somewhat to my surprise, led to a shift in my identity-story. New possibilities for action as well as conceptualization opened up. I discovered that conducting research and reading research articles informed my clinical practice, and that my clinical practice informed my research activities. I now reflect more than ever on my clinical work and in teaching and research spend a great deal of time creating a balance between theory, practice and research. Conducting research became a rich and interesting endeavor with practical implications.

In writing this narrative, and reflecting upon my experiences, I believe that it was important to have a community that supported and tested my development as a researcher, clinician and instructor. As when working with a team to develop one's clinical skills, having access to qualitative research courses (or colleagues to consult), and faculty and colleagues to guide, challenge and support one's research is consequential. Through this support, one can develop rigor, imagination and ethical practices in research, practice and instruction.

RESEARCHER/PRACTITIONER: CLOSER TO THE TALK
RONALD J. CHENAIL

For the past seven years as a qualitative researcher and family therapist, I have studied the practice of therapy by closely examining the way therapists and their clients speak in clinical sessions. I have not been particularly interested in the psychological or social systems theories that underlie the practice of therapy. Instead, I am more curious about how therapists, clients, supervisors, and other participants in therapy conduct themselves in these therapeutic conversations.

Use of Words in Therapy

I like to study how people speak when they are being therapists or clients. I want to know how people use words in their attempts to express their emotions, ideas, situations, and problems. I am fascinated with the ways therapists use their words to open up new vistas in conversations and how these fresh avenues in the talk seem to help people feel better and allow them to try new ways of living in and relating to the world.

My curiosity with talk in therapy extends to my practice as a family therapist. I have come to believe that whatever theories of personality, family, or systems a therapist holds, the practice of therapy boils down to having a conversation: albeit a particular kind of a conversation, but a conversation nevertheless. To be a therapist, I have to know how to use words. I have to be able to listen to what others say in the therapy room. I have to be able to speak with clients, to use their language.

I have to be able to track what is happening in a particular therapeutic conversation. Conversations are tricky phenomena, especially with families in therapy contexts. It seems in a moment's notice that a calm, constructive flow of talk can erupt into a chaotic, destructive torrent of screams and yells. Like all face-to-face interactions in language, therapy conversations can turn on a word. For instance, a "things are getting better" line of talk in a session can quickly turn into a "I still can't understand why he did it" refrain simply by the use of one little word: "but."

Redundant, Stagnant Talk

At other times, the talk can become redundant and stagnant to the point that there appears to be no movement. In these moments, therapist and client cover and re-cover the same stretch of talk over and over again. The pattern of talk in the therapy sessions takes on the same stuck pattern the clients have been experiencing in their out-of-session conversations.

As the therapist I feel that I need to track the talk and to recognize this change, or lack of change, in the conversation. By doing so, I can better choose how I will participate in the conversation. Hopefully, these choices made will help to increase the possibilities that the conversations we have together as therapist and clients will become alternatives to the troublesome ones in which they have been participating and to help us all reach a more therapeutic way of interacting.

Recursive Frame Analysis

In this essay, I want to discuss how I have conducted a number of qualitative studies as a therapist and as a researcher to learn more about talk and talk about talk of therapy. To this end, I will describe a qualitative approach to the study of discourse I have helped to develop called Recursive Frame Analysis (RFA). First, I want briefly to discuss some basic assumptions and techniques of RFA. This should help acquaint those readers who have not been previously introduced to Recursive Frame Analysis. Second, I want to illustrate how taking a closer look at clinical

discourse through an RFA lens has helped to inform the way I speak and listen in therapy sessions.

To learn more about how others and I use and understand language in therapy and other such conversations, I have helped to lead a qualitative research project dedicated to the construction of a practical and useful way to "get closer to the talk." The system which has evolved in our project is called Recursive Frame Analysis (RFA) (Chenail, 1991). Created by Bradford Keeney, RFA is a method for understanding and presenting conversations. It is a type of sequential analysis which helps researchers and therapists to note their perceptions of semantic shifts in a conversation.

I have used this method to research a variety of conversations. These studies include an examination of parents' conversations about their children's heart murmurs (Chenail, 1991), a description of family therapist-supervisor talk behind the one-way mirror in a therapy session (Chenail & Fortugno, in press), an analysis of divorce mediator-disputants discourse in child custody dispute resolution (Chenail, Itkin, Bonneau, & Andriacchi, 1993; Chenail, Zellick, & Bonneau, 1992), and an in-depth look at systemic family therapy discourse (Rambo, Heath, & Chenail, 1993). Through each of these studies I was able to learn something different and something new which can happen when two parties sit down to discuss how to solve a problem.

RFA Assumptions

The roots of Recursive Frame Analysis can be traced to the work of Gregory Bateson (1972) and Erving Goffman (1974). Bateson and Goffman understood frames as being our conceptual or cognitive views of particular situations. For instance, do we perceive a story we hear from a client to be a tale of problems or of solutions? Our choices of frames help us to hear certain aspects of the talk, while not helping us to hear other parts of the conversation.

Along with this conceptual understanding of frames, Recursive Frame Analysts also employ what Deborah Tannen and others (Tannen & Wallat, 1993; Putnam & Holmer, 1992) call "interactive frames." Interactive frames are linguistic patterns through which we create meaning in our conversations. We build our conversations word-by-word and understand the words we hear and use in conversation by how we contextualize them. To contextualize or to frame a word is to connect it with other words. Context is built by the ways individuals connect words with other words in conversations.

For example, each sentence I have used so far in this essay has been built by connecting words. For you, the reader, each word I use already

comes with a "dictionary" meaning. Each word has its own meaning for you prior to my using it in a sentence. When you come across a word like "frame," you have to look around at the other words I have used along with "frame" in order to construct how I am using and not using "frame" in a particular sentence. "Frame" understood in context means that you construct the meaning of "frame" by understanding it along with the other words around it.

The notion of recursion comes into play with Recursive Frame Analysis in that our cognitive frames are in recursive relationship with the linguistic frames we speak and hear. Our understanding of a situation helps us to grasp "what is going on." At the same time, as we experience "what is going on" in a situation, our understandings of that event can be re-shaped or reframed.

For example, if a therapist understands therapy as a "teaching" situation, he or she organizes therapy into "lessons" and "evaluates" how well the client has "learned." If the client does something in therapy which the therapist has never experienced before, the therapist may then see therapy as a "learning" opportunity and begin to appreciate what can be learned from the client-as-teacher.

Also, in conversation, there is a recursive relationship between text and context. A particular piece of text contextualizes other text, and in turn, is also contextualized by the other surrounding bits of text. If someone talks about success in business in terms of "scoring big with a contract" or "slam-dunking the competition," we can hear that this person contextualizes business in a sports frame. At the same time, these juxtapositions can lead us to think of sports in business terms too. For instance, newly hired chief executive officers in businesses can sign contracts that pay them for scoring big, and basketball players can compete against each other for money in slam dunk competitions during all-star games.

RFA Practice

With RFA, researchers listen to or watch a recording of a conversation while reading and re-reading a transcript of the discourse in question. They (a) discuss their observations of the subject matter of the conversation being developed (i.e., an emphasis on *content* or *what is being said*) and (b) note shifts from one subject to another in the course of a conversation (i.e., an emphasis on process or how things are being said).

An RFA analysis proceeds as follows: After the recording has been perused numerous times, the team members note instances when speakers use words repetitively. Then the team begins to "chunk" these instances into informal groupings. In RFA, chunking is the process by which an

observer or team of observers makes sense of a collection of data by gathering together those discourse examples which seem to the observer(s) to have some characteristics in common. In RFA lingo, we say that we chunk these frames into galleries.

For example, in a therapy conversation, one gallery that can usually be constructed is a Problem Gallery. A problem gallery is a chunking that would contain all those frames uttered by the client(s) that the therapist or researcher understands as "problems." Another gallery commonly chunked by therapists would be a Solution Gallery. Again, this gallery would be a chunking of all the frames understood as being solutions or possible remedies by the therapist or researcher. In both cases, the therapist's or researcher's chunking of the frames may or may not be the same as how the client understands the conversation. In addition, other therapists or researchers may also differ on how they chunk the talk.

From an RFA perspective, this type of disagreement is fine because the purpose of RFA is not to make the map of the interaction, but only to make your map of a conversation: One based upon your understanding of the talk. When I write up RFA research, I present the analysis as my conceptualization of discourse. I re-present the data alongside my analysis and I encourage readers to judge the readability of my RFA map: Can readers follow how I have delineated the galleries and frames? Do readers agree with my rendering of the case? Readers could make their own RFA maps from the transcripts.

Similarly, as a therapist, I use RFA to chart how I understand a therapeutic conversation to be unfolding as I participate in the session. Again, I understand that these chunkings of the talk are my own constructions. In therapy, these RFA's are not as detailed as those I construct as a researcher. The speed at which a conversation unfolds in real-time does not allow me to create an intricate map as a therapist.

Also, I judge my in-session RFA's as good only when they help me work with the clients. Therefore, I keep my patterns of galleries simple and readily discard them if they do not help me get closer to the client's talk. For instance, I can always tell if my mapping of the talk is "off" in a session because the clients will tell me that what I am saying does not make sense to them, or they will continue to repeat their story several times in the therapy. If either situation occurs, I do not argue with the clients and tell them that my map is the map and that they are wrong about their understanding of their own situation. Rather, I know I must discard my present RFA understanding, listen anew to the clients' stories, and create a new pattern of galleries and frames.

RFA-Informed Therapy: Three Examples

To help the readers understand how RFA research has informed my practice of therapy, I would like to discuss briefly three in-the-room-processes that I first noticed as an RFA researcher and then subsequently used as a therapist. These patterns of talk are torqued talk, opening up closings, and closing down closings. Most of the therapy I practice and supervise nowadays is organized by these three talk distinctions. As a result, I find that by concentrating on whether I think the talk seems to be "standing still" (torqued talk), or whether I gather that the talk is "moving from one gallery to another" (opening up closings), or whether the talk only appears to be moving from one gallery to another, I can better gauge how I want to participate in the conversation at a particular moment in time.

Torqued talk. Most clients come to therapy because they feel that they are stuck. They do not know what to do with a life situation, or, if they do know what to do, they are unable to accomplish their goal(s). By tracking the frames in therapy with RFA, I can usually notice how tight the talk can be for clients. They will repeat their stories, sometimes word for word, again and again in the sessions. The rigidity or tightness I experience in these conversations led me to describe this talk as being torqued. By torqued, I mean that the talk seems twisted tightly and that I am having trouble hearing any changes in the clients' wordings.

In a recent study (Rambo, Heath, & Chenail, 1993), I examined a full-length family therapy session. The family had come to therapy to discuss how a son, "Randy," could move into his father "Ted's" home to live. The son's mother and father had been divorced a number of years. During that time, the son had lived on and off with his mother and her new husband, his father, and an uncle.

During the session, I had chunked a number of frames into a gallery I called "Randy and Ted Getting Together Talk," a possible solution gallery. The talk in the conversation returned to that gallery nine times. Seven of those nine times, the "getting together talk" was followed by another gallery, "Ted's Problem with Randy Talk," a problem gallery. To me, the repeated solution gallery and problem gallery juxtaposition seemed to be a good representation of torqued talk.

Many therapy sessions can be seen as having a pattern of torqued talk similar to the one I experienced in studying the case with Randy and Ted. Until some new bit of talk can be introduced into the conversation, both the talk in the therapy room and the clients' situation outside of the room will remain stuck. One technique I have learned that can help in untorquing talk is the opening up closing.

Opening up closings. RFA can be used for conducting a sequential

analysis of discourse. As in the case above, the Recursive Frame Analyst charts the flow of conversation and marks when conversations shift from one chunking to another. For instance, the analyst may mark when a conversation shifts from talk about the children's school problems to talk about the children's problems at home. The talk may then shift from talk about children's problems to talk about the husband's and wife's problems. In each instance, the researcher or therapist would mark or take note of when they would notice one of these shifts.

Along with charting changes in meaning, or semantic shifts in these conversations, a Recursive Frame Analyst may also take note of who is initiating these shifts and how the particular speaker is able to successfully move the talk from one gallery to another. The term I use to note this shifting phenomenon is called opening up closings (Schegloff & Sacks, 1973), a distinction I have borrowed from conversation analysis. With an opening up closing, the speaker uses certain words which open up a new line of conversation, while simultaneously closing down the current topic of talk. In RFA terms, one gallery is opened up as another is closed down.

In studying the discourse of divorce mediation, a group of colleagues and I (Chenail, Itkin, Bonneau, & Andriacchi, 1993, October; Chenail, Zellick, & Bonneau, 1992, October) became curious about how divorce mediators were able to help disputing parties come to resolutions regarding child care, custody, and support. In many of these cases, the ex-husband and ex-wife had not had much success in getting along with each other, much less working out complex agreements over their child or children.

When we examined the transcripts of more than 30 divorce mediation cases from an RFA perspective, we noted a number of times that the mediator was able to open productive resolution talk, while at the same time closing down unproductive fighting talk. As we looked closer at these gallery transition moments, we noticed that the talk took its turns when the mediator reminded the parties that they were both at the mediation sessions for the best interests of their child or children. That move on the part of the mediator helped to open up a new line of talk different from the preceding line of conversation in most of the cases we observed.

Closing down openings. My RFA research on conversations has also helped me to notice another interesting speech act, the closing down opening. This type of talk occurs when one speaker appears to offer an opening such as, "I really think that that might work . . . " and then follows it up with a closing down ending such as, " . . . but not with this situation." In other words, whereas an opening up closing opens up a new talk gallery while closing down a currently active gallery of talk, a closing down opening only appears to offer the possibility of a new gallery to the other

in a conversation. Closer attention to the use of "Yes, but" in therapy has helped me understand how seemingly promising lines of therapeutic talk can be quickly shut down, and how I can possibly change the situation without becoming part of the torqued talk.

In the full session analysis (Rambo, Heath, & Chenail, 1993) which I mentioned above in the Torqued Talk section, I became fascinated with how the various members of the family used "Yes, but's" to create what seemed, on the first take, to be openings for solution talk, but on the second take, appeared to move the talk nowhere. For instance, Ted, the dad in the session, said " . . . and, he's (Ted's roommate Nathan) said right now he doesn't mind. He won't mind if Randy (Ted's son) comes in, but he told me point blank if we have any problem one of them is going to go" (Rambo, Heath, & Chenail, 1993, p. 175). Ted's talk about Nathan not minding sounds like an opening for a "Ted, Nathan and Randy Getting Along" Gallery. The promise of such an opening comes crashing down just a few words later as Ted says, " . . . if we have any problem one of them is going to go" (p. 175).

I like the irony of this type of speech act: The words appeared like an invitation to an opening, but in truth they were helping in keeping the talk so stuck. If the therapist made a move to open up some "Getting along" talk, the "one of them is going to go" closing of Ted's speech cuts off that gallery. If the therapist heard the "one of them is going to go" talk as an opening up of a "Ted, Nathan, and Randy Not Getting Along" Gallery, the previously opening up talk of the "right now he doesn't mind" now becomes a closing down line to that gallery.

Presented with such a dilemma in conversations, I have learned from my qualitative discourse analyses to treat closing down openings not as "either/or's," but as "both/ands." To do so, I have to build a new gallery in which both lines of a closing down opening talk (i.e., the "Yes" part and the "but" part) can become woven together. In the case mentioned above, I could use an opening up closing such as, "It sounds like both possibilities could happen: that Nathan and Randy might get along and then again, they might not be able to get along. Given that situation, Ted, how do you want to proceed?" In this way, I can ask Ted to open up a new gallery (i.e., a "What to do" line of talk) and listen to where that gallery takes us.

Conclusion. From the years of analyzing sessions from an RFA perspective as a researcher, I feel as if I am operating from within the talk in therapy. As I am engaged in the clinical hour as a therapist, I am also participating as a discourse analyst. I find this reflective stance helps me to

stay closer to the process within the therapy room both as therapist and as researcher.

After seven years of using RFA as an aid to my listening, I have begun to develop "a sharper ear." Now, I find that I can trace what is being said, who is saying it, how the talk has changed, how the talk has stayed the same, and how I can participate in the conversation, all at the same time. It is almost akin to listening to a symphony: you can follow the melody, note the key in which it is being played, notice what part the violins are playing, all while humming along with the tune. In this way, RFA has given me a whole new appreciation for talk and how it works.

ONE CLINICAL RESEARCH TEAM'S EXPERIENCE WITH HERMENEUTIC INTERPRETATION

WENDY L. WATSON
LORRAINE M. WRIGHT
JANICE M. BELL

"There is something different about your clinical work." In the mid-80s that phrase became a theme of the comments on our national and international presentations. The commendation that our work was different from others caught our attention especially when voiced by other clinicians who were familiar with the work of those who had influenced our clinical practice: the Milan team's systemic elegance, Michael White and David Epston's narrative notions, and Maturana's biology of knowing.

Through 10 years of clinical practice we (Watson and Wright) had co-evolved a clinical approach that we have named Systemic Belief Therapy (SBT). One of the major premises of SBT is that the belief about the problem is the problem. For example, when a family is experiencing difficulties with cancer, depression or marital conflict, we believe it is their beliefs about the problem that become the problem. Our clinical effort was therefore focused on drawing forth and challenging the belief at the heart of the matter, i.e., the constraining belief that perpetuates and is perpetuated by the problem.

But how did we really do that? What *was* "different" about our clinical work? What was involved in the process of our therapeutic approach that brought about those seemingly "miraculous" changes with families? What happened in the therapeutic conversation between the clinician and the family so that the constraining belief was challenged and facilitative beliefs were supported or offered? What was the process of therapeutic change involved in our clinical approach, Systemic Belief Therapy?

Our previous research had focused on examining: (1) the relationship

between chronic illness and family functioning (Watson, Bell & Wright, 1992; Wright & Bell, 1989); (2) the effectiveness of family systems nursing/family therapy interventions (Watson, Bell & Wright, 1992); (3) family outcomes; and (4) the education and supervision of family systems nursing/family therapy clinical practice (Wright & Bell, 1989).

Transitions to Clinical Research

The ideas gleaned from those research projects were useful. After a while, however, as a clinical research team, the three of us were asking questions we found compelling and that invited different research approaches. We wanted answers that were more than statistically significant. We wanted clinical significance! We wanted to engage in research that would push our understanding and articulation of our clinical practice to new and higher levels. We were dissatisfied with examining clinical work in a manner that had little relevance for clinicians. Examining effectiveness is a useful enterprise, but clinicians want to know they are making a difference. The usual effectiveness designs have little meaning in terms of changing, shaping, refining, and articulating the clinical work. We were attracted to process research that allows clinical research teams to ask different questions about the clinical work and allows a different kind of research to emerge. Qualitative methods are particularly well suited to looking at the therapeutic process.

Nursing and Qualitative Research

At that time, the three of us were working in the discipline of nursing. Nursing, like education, has been a discipline that historically has been attracted to qualitative research. In fact, many of the leaders in the qualitative movement have been and continue to be nurses, including Patricia Benner (1994), Katharyn May (1991, 1994), Janice Morse (1992), Patricia Munhall (1988), Margarete Sandelowski (1986, 1984), Phyllis Noerager Stern (1991), and Toni Tripp-Reimer (1985a, 1985b). Our dissatisfaction with quantitative approaches centered on the compression of human experience into a few variables as well as the ongoing clinical sense that there was something more to discover than quantitative measures and procedures could offer us. This dissatisfaction nurtured our desire to approach our next inquiry through a qualitative research approach.

Qualitative methods were appealing to us as clinical researchers. They seemed rich, humane, and congruent with our beliefs that clinician/researchers are part of the observing system. Qualitative methods also resonated with our beliefs about reality. For years in our clinical practice and

teaching we had eschewed positivism, the foundation of quantitative research approaches. Our belief that realities are not embedded in certainty but rather are co-evolved through our interactions with others drew us toward qualitative approaches. Thus, our passion for qualitative research with families grew. We saw it as the preferred way for us to study families in general and family intervention and change in particular. We increased our appreciation of qualitative research approaches' appreciation of the lived experiences of families *and* of researchers.

Research on the Processes of Therapeutic Change

In 1992 we received funding to study the processes of therapeutic change. We were ready and keen to articulate our clinical practice. Janice Bell, a colleague who joined our team as research coordinator in 1986, was the principal investigator of the study. Our consultant was Catherine Chesla, a former student and colleague of Patricia Benner (1994), a respected hermeneutic nursing researcher. Under Chesla's tutelage, we developed our skills in hermeneutic interpretation.

Our clinical research team (Bell, Wright and Watson) reviewed all the families with whom two of us (Watson and Wright) had worked from 1988 to 1992 and chose five exemplary cases. What constituted "an exemplary case?" It was a case where the family showed: (1) dramatic cognitive, affective or behavioral change during the family therapy sessions which ranged from 2 to 5 sessions (both during session change and across session change was noted); and (2) improvement in the presenting problem 6 months following termination of the family therapy sessions.

We began our journey into "Hermeneutic Discovery Land" by viewing the previously videotaped clinical sessions of one exemplary case. This overview gave us an initial sense of the clinical work with the family. Next, each member of the research team separately selected segments of the interview she considered salient to the process of therapeutic change. This was done by studying each interview to see how the clinician responded to the family and how the family responded to the clinician. The question that guided each team member's selection was, "Would there have been as much change with this family had this particular interaction not have occurred?" Our research team then convened to discuss their choice of change segments to arrive at consensus among the team and to exchange rationale (sometimes passionately) for and against the selection of a particular change segment. Once team consensus was reached, the change segments were transcribed.

Hermeneutic Analysis

Our hermeneutic analysis proceeded in stages. The first stage was separate analyses of the transcribed change segments. The second stage was discussing our analyses. We videotaped our discussions, and, in the third stage, we analyzed the videotape for further insights into therapeutic change processes.

In our separate analyses, we each answered the following questions: (1) What is the broad and the immediate context of this change segment? (2) What is happening here from the clinician's perspective and from the family's perspective? (3) Is this move or intervention unique or is it similar to another? and (4) What else could we call it? Each of us wrote our responses to these questions.

We were continually trying to give new language and see with new eyes the kinds of movements that were occurring in the segments salient to the process of change, and the written word afforded us that opportunity. One of our team members (LW) described her experience with hermeneutic interpretation of the transcriptions this way:

> My initial reaction to the idea of the hermeneutic process was that observing videos and then transcribing and interpreting the transcriptions would be time-consuming and unnecessary. After 20 years of clinical experience, I felt quite able to target segments of change and comment on them without having to review text. However, this came to be one of the greatest and most humbling changes in my beliefs about "seeing" and interpreting clinical work. The reason being that what I "saw" on video and what I "saw" in the transcriptions were not the same. Therefore, my interpretations were also different. I entered into a totally different domain through the analysis of text. It was as if I was at times, looking at therapeutic change and my clinical work with an entirely different lens and therefore discovering some aspects of my clinical work for the first time. Themes, patterns, and powerful uses of language leapt off the page at me and there was the privilege of being able to ponder the words, reflect on a phrase and marvel at the change evident on a single page.
>
> One of the research families was a young 27 year old man experiencing MS, and his parents. During the second interview, a change segment was identified which our research team labelled as 'distinguishing the illness experience.' In the videotaped version of this change segment, I observed myself seeking to draw forth various distinctions about the illness, i.e., asking difference and relative influence questions. However, in my hermeneutic analysis of the text

of this change segment, I wrote, 'One belief of mine that is challenged from the text but that I do not remember having an impact on me during the interview, nor in the videotape review, is the notion that the son does not believe that he influences his illness but rather believes there are things that he 'does in spite of' his illness. This response lifts the illness experience out of the control paradigm, upon which the line of inquiry about relative influence is based, and moves the illness experience into some other paradigm . . . perhaps the 'in spite of illness' paradigm. I will not forget this notion. The latter was a totally new idea for me reading the text.' This was one of many examples of how the written word invited new reflections and new distinctions.

I have come to believe that the text speaks a different language and we involve ourselves with text much differently than with videotaped or live sessions. It has reminded me of the phenomena of going to a movie and then reading the book. There has always been the tendency to criticize the movie for not capturing what was in the book–but how can it (or vice versa)? This was the same experience with observing our videos of our clinical work and then reading the transcripts of the sessions. They are totally different domains of understanding and of course one cannot give what the other gives. But I believe both are essential for any clinical researcher to experience in order to truly capture the many subtle nuances and changes that occur within individual family members, within the clinician and between the clinician and family.

When each team member had analyzed the transcripts and written out their analyses, we sequestered ourselves for days at a time with only our individual analyses, lots of food, laughter and a great desire to learn to sustain us. We called ourselves the "Hermeneutic Hermits!" Our research assistant and the video-camera were poised and ready to record our comments, concerns, conversations and hopefully some cutting edge ideas. We engaged in intensive, synergistic processes, hoping that from these team hermeneutic interpretation sessions we would construct a proliferation of pearls of understanding about the therapeutic processes that had previously eluded us.

The convincing "data" that the research process was exciting and synergistic are the numerous videotapes of the three of us completing the hermeneutic analysis as a team following our individual analyses. This is an unusual collection of data and we are unaware of other research teams that have videotaped their process of conducting hermeneutic analysis. It would be useful for another researcher to analyze those videotapes for the process events of our particular team. However, the most significant

examples of our synergism and co-evolution of ideas were the writing of interpretive memos.

Interpretive Memos

We wrote interpretative memos about "creating the context for change," "distinguishing change," and "beliefs." Through the offering of ideas and asking questions of each other regarding these macro-moves, we experienced the excitement and exhilaration that accompanies the co-evolving and co-generation of further clarifications, distinctions, and descriptions of important clinical moves. We found ourselves under the hermeneutic spell. We consistently and more passionately were committed to the incredible process of weaving in a multiplicity of ideas and building upon each other's ideas, savoring the experiences of synchrony as well as the serendipitous conceptual leaps. We were most amazed that the labor intensive process was predominantly energizing, not enervating; productive, not pathetic; and actually fun, not frustrating!

Just a footnote: In the spirit of giving moves and interactions new names, we initially called these team interpretation sessions, "Synergistic Hermeneutic Interpretation of the Team," but abandoned it when we realized the acronym "S.H.I.T" did not in any way capture how we felt about these tremendous think tank times.

The process of: (1) team overview of all sessions; (2) individual selection of change segments; (3) team consensus of change segments; (4) individual hermeneutic interpretation of transcriptions of change segments; and (5) team hermeneutic interpretation was then repeated with the other four exemplary cases.

What did this qualitative process unfold? We discovered and uncovered aspects of our clinical work that had been out of our awareness. We co-evolved a new language, a refined understanding and an increased ability to articulate our clinical practice. For example, for many years we had encouraged our students to "create a context for change." But now, we had micro-moves that were part of our way of creating the context for change: therapeutic micro-moves such as "the goodness of fit conversation," or "proclaiming the prematurity of progressing at this point."

Major moves such as "distinguishing the illness," "distinguishing change," "challenging beliefs" and "solidifying beliefs" accompanied by a multitude of micro-moves were among the other "outcomes" which defined our clinical practice. Some of the micro-moves involved within the major moves were: (1) clearing away the debris; (2) the goodness of fit conversation; (3) proclaiming the prematurity of progressing; (4) the gambler's rhythm; and (5) reciprocal balancing.

Additionally, other palpable products of our hermeneutic inquiry included: (1) the power of language (by family members and the clinician); (2) the power of family beliefs about illness; (3) the power of the beliefs of health care professionals in empowering or disempowering families; and (4) the power of witnessing/validating families.

Journeys into Commitments

The journey into "Hermeneutic Discovery Land" was also a journey into commitments. Through our qualitative research experience we have discovered a greater desire to acknowledge the learning that families give us and to give that learning back to other families and to give credit where credit is due by telling other families where we gained that knowledge that we are passing on. We have an ever increasing desire to conduct research for the purpose of helping families, not for pleasing funding agencies, or for our own merits and rewards within academic life. We desire to scrutinize our clinical practice, teaching, and research with the question, "Will this help us help families?"

And finally we are more passionate about working as a clinical research team even though separated by a thousand miles on a day to day basis. We have come to believe that, as in therapy, the most creative, thoughtful, and perhaps even ethical work is that which occurs within a *team* of researchers. The synergism, the co-evolution of ideas, the multiple minds add to the richness and credibility of both the process and the outcome of the work.

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