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Reflections from behind the screen: avoiding therapeutic rupture when utilising reflecting teams

Abstract

Since Tom Andersen developed the use of reflecting teams to facilitate the progress and process of family therapy, little empirical evidence has emerged regarding their effectiveness or use in therapeutic practice. Reflecting teams are typically embraced by family therapists as a positive mechanism for enhancing practice and thus it is important that research explores how they are utilised. In this paper we draw upon video-taped data of naturally occurring family therapy from the UK. Using conversation analysis we identified three performative actions related to interrupting the therapeutic coversation to consult with a reflecting team. We found that therapists had difficulty exiting therapy, that on some occasions exit was hindered and that there were disturbances in feeding back the reflections of the team. By examining the use of teams in real practice we were able to make a number of recommendations for practicing family therapists to facilitate the use of this valuable resource.

Relationships within families can experience problems (Hutchby and O'Reilly, 2010) and family therapy is designed to help manage these difficulties. Family therapy sets out to 'treat' the family system and conceptualises the problem as situated within the dynamics of the family. Systemic family therapy is a popular form of family therapy which aims to facilitate change in the family system (Barker, 1998). During this therapeutic endeavour, the therapist may encounter a 'stuck system' where the family members have become restricted by an insular way of thinking (Andersen, 1987). To deal with such problems, a novel approach was promoted by Tom Andersen (1987) to encourage families to generate a wider range of perspectives to explore solutions by utilising a reflecting team.

There are a broad range of family therapy models which utilise reflecting teams in slightly different ways, and over time there have been a number of historical changes (Haley, 2002). Typically (although not exclusively) the reflecting team consists of several professionals from differing backgrounds who sit behind a one-way mirror to observe the interactions between the therapist and family (Lange, 2010). By using a reflecting team, at various junctures in the therapy, the therapist leaves the family to consult with the team and later reconnects with the family to offer a new understanding of their problems (Andersen, 1992). Thus, family therapists use the reflecting team to generate hypotheses, organise interventions and assist them in their decisions and processes (Cole *et al*., 2001). Problematically, the practicalities of physically leaving the family to consult with the team and subsequently to re-enter the room to return to the therapeutic conversation is something that has attracted less attention in the literature. Unfortunately therefore, there is little research evidence providing guidelines for managing this effectively. Engaging a reflective team allows discussion of sensitive topics in a way that affords families the opportunity to accept or reject those introduced perspectives (Smith *et al.*, 1992). The presentation of diverse messages, whilst potentially generating alternative perspectives which can illuminate the family's difficulties, also require therapists to allow

family members reflective time to process those messages (O'Connor *et al*., 2004). It is therefore important that the reflecting team are careful regarding the amount of information they present so as to distil their thoughts to the most salient contributions (Smith *et al*., 1992). It is evident therefore that the re-presentation of comments made by the reflecting team is integral to the effectiveness of this approach, however, there is little empirical evidence to illustrate how this is actuated in practice.

Since their introduction, the use of reflecting teams has had considerable impact and has been met with enthusiasm by practitioners, and yet there is little research evidence in this area (Chang, 2010; Willott *et al*., 2010). Reflecting teams are an expensive and time consuming resource (Lange, 2010), and in the current economic climate of austerity measures it is essential therefore that we have a research evidence base to demonstrate the most efficient use of these teams. Our analysis provides an empirical foundation for therapists working in this modality. Arguably, to acquire this evidence base, the most appropriate form of research is the examination of actual talk in therapy sessions, as this has potential to reveal the adequacy of existing theoretical accounts about the therapeutic relationship (Roy-Chowdhury, 2006). One of the most congruent research methodologies to use with family therapy is discourse and conversation analysis, as this offers a rigorous tool to examine language which is a central concern for therapy (Burck, 2005). In this article we address the question of how language is used in family therapy as a performative resource in managing the process of engaging, and reporting back the comments from, the reflecting team. This is an important issue to address, in relation to providing evidence regarding the potential and clinical effectiveness of this expensive resource. Our aims are to investigate 3 core issues: first, the negotiation of the therapist's exit and re-entry into the therapeutic space, second, the potential for therapeutic rupture at these junctures, and third, how information is imparted from the reflecting team to the family via the therapist and how this information is received. Our objective is that through utilising a rigorous language-based methodology we may explicate the details of these processes in a way that will be salient in informing clinical practice.

Method

This research employs a form of qualitative language-based approach to investigate the ways in which reflecting teams are utilised by family therapists in practice.

Setting and context

The data used in this research was provided by a systemic family therapy centre based in the UK. Actual family therapy sessions were recorded and approximately 22 hours of family therapy, from four different families (pseudonyms, Clamp, Niles, Bremner and Webber) and two different therapists (Pseudonyms, Kim and Joe), were provided for analysis. The Clamp family consisted of two parents, one uncle and three children (Phillip, Jordan and Ronald). All three children are reported to have difficulties. The Niles family consisted of two parents and four children (Steve, Nicola, Lee and Kevin) with Steve being suspected of having ADHD. The Bremner family consisted of the mother and grandmother and two children (Bob and Jeff). Bob had been diagnosed with Asperger's Syndrome and Jeff was described by the family as being 'handicapped'. The Webber family consisted of two parents and four children (Adam, Daniel, Patrick and Stuart), with Daniel being identified by the family as the child with difficulties and sexual deviation.

All four families were White British, from the Midlands are of the UK and from lower socio-economic backgrounds. In keeping with the deductive epistemology, sampling was appropriate and issues related to saturation were not intrinsic to the approach (O'Reilly and Parker, in press). The video-taped data was subjected to transcription in accordance with the analytic method and Jefferson guidelines were followed (See Atkinson & Heritage, 1999).

The language-based approach

A particularly useful qualitative approach for studying family therapy is discourse analysis as this is methodologically congruent with the theoretical framework of family therapy (Roy-Chowdhury, 2003). There are a number of different forms of language-based analysis and for our research we used

the micro-analytic approach of conversation analysis as this allows the systematic exploration of the nuances of interaction. Pioneered by Harvey Sacks, conversation analysis (CA) seeks to analyse naturally occurring interaction. CA focuses on the ways in which social realities are constituted through talk-in-interaction (Scks, Schegloff and Jefferson, 1974). In other words CA is concerned with the detailed analysis of how talk-in-interaction is conducted (Schegloff, 1992). The use of conversation analysis therefore, "*makes intuitive sense. Therapy is intrinsically a conversation…*" (McLeod, 2001: 91). The use of this method provides a means for addressing the aims of this research as it facilitates the exploration of the detailed sequential processes involved in talk around the exit and re-entry points of the therapeutic conversation as therapists leave the room to consult with their reflecting teams.

Ethics

For our research we utilised the principlist approach to ethics, incorporating the four core principles of autonomy, justice, beneficence and non-maleficence (Beauchamp and Childress, 2008). In practice this meant that informed consent was collected from managers, therapists and families, plus all identifying features were removed from transcripts and data was stored securely.

Findings

Three core performative actions emerged from the data. First, therapists used linguistic strategies to create a break in the therapy in order to exit the room, often accompanied by an account. Second, there were occasions where the therapist was unsuccessful in attempting to leave the room due to therapeutic rupture. Finally, there was variability in the success of conveying the thoughts of the reflecting team upon re-entry. By examining these in detail in actual practice we were able to make a number of clinical recommendations which were shown to facilitateinterruptions to the therapeutic process.

Performative action 1: Exiting therapy

Due to the format of family therapy sessions and the inclusion of a reflecting team, there is a necessity for therapists to create opportunities to consult with the team. The particular sequences of talk

initiated by the therapists in our data included, linguistically pre-empting physical exit, minimisation of the length of time out of the room (and therefore absent from the therapeutic conversation), and organising their final turn in a way that discouraged further contributions. Typically this was accompanied by an account for the exit.

Extract 1

FT: Okay at some stage I might nip o:ut (.) jus’ t’ see if they've got any ideas, that might be ↑helpful erm it gives you a bit [of space as well to think about (1.0) =
Dad: [Yeah]
FT: = or what you think about me and what we've been doing

(Clamp family session 1)

This extract was taken from the early stages of the first family therapy session. The therapist’s turn acted as a ‘pre-announcement’ (Sacks, 1992) of the necessity for potential forthcoming exit. . Warning the family in advance that there may be breaks in the therapy to talk to the reflecting team and thereby pre-empting future departure may mitigate against possible therapeutic rupture, and thus facilitate an effective exit.

Extract 2

FT: I’ll just >nip next door< t’ see how they decided on what t’ do ↑see if they’ve got any ideas >okay< back in a few minutes ((therapist stands))
Bob: Mumm[y pick a number
FT: [See you in a minute
((therapist leaves the room))

(Bremner family session 1)

Extract 3

Dad: and then you would be able to kind of watch him in and see well you know what I mean you would never ever get anything out of him more than that (.) situation (.) you know what I mean
FT: I’ll go and speak t’ the team >for a couple of< minutes give you a bit of space as well

(Webber family session 3)

Minimising the amount of time out of the room is highlighted by these two extracts *‘nip next door’* and ‘*couple of minutes’*. Drawing attention to the minimal time that will be taken out of therapy functions to both provide a frame within which the consultation with the reflecting team can occur, and mitigates the potentially detrimental effects of having a break in therapy. The efficacy of this approach as an exit strategy is facilitated by active discouragement of further contribution from family members which may delay or prevent departure. For example, in extract 2 the therapist does this by

standing up as he announces his imminent exit. In extract 3 the therapist initates a topic shift (Jefferson, 1993) in order to create an opportunity to leave the room. We argue therefore that the therapist needs to either wait for or create an appropriate ‘exit relevant place’ (ERP) to exit the room in order to consult with the reflecting team. In normative conversations the junctures between turns are commonly referred to as ‘transition relevant places’ (Sacks *et al.*, 1974). These are convenient moments in the conversation for another speaker to take a turn of the conversational floor without breaking the conventional rules of turn-taking. We propose therefore, that in a simiar way, an ERP is a place in the conversation whereby the therapist can exit without damaging the therapeutic alliance. In other words, without disrupting the normative relational processes.

Extract 4

FT: I’ll I’ll go and speak with ↑Carla >in a bit< so you’ll ‘ave a (.) bit of spa- you can >nip out< and have a quick ciggie if you want as well
Mum: No ‘e can’t he can ↑wait
FT: >I mean< I won’t be long
Dad: I’ll stick me ‘ead out the win↑da((Smiley voice))
FT: ↑In fact (.) do yer want me t’ leave you finishin’ off that list if if >the two of you< do your ↑own list (.) which ones of those you think are like Steve (.) I’ll go an’ talk t’ Carla (.) and I’ll be back in a minute

(Niles family session 1)

Extract 5

FT: Well (.) >I mean< actually I I’d quite like t:o (.) t’ jus’ go an’ hear what the (.) my (.) my collea:gues are thinkin’ ↓really
Dad: ↑Yeah
FT: cuz we’ve talkin’ is quite
(1.4)
FT: quite intense
Dad: Hu::m

(Clamp family session 3)

Typically accompanying an exit from therapy in this data corpus was an account for that departure. Offering an account for exit is indicative that the therapist treated temporarily leaving the therapysession as accountable. Our data revealed two main types of exit account. First the therapist accounted for departure by showing that there was a need to collect further information from the reflecting team to facilitate his/her observations (refer back to extract 2; ‘*see if they’ve got any ideas*’.). Although the primary function of leaving the room was to engage with the reflective team, a second type of account provided in situ was to propose the exit as beneficial for the family. This was

done both overtly *'you'll have a bit of spa- '* (extract 4) and by implication, *'cuz we've talkin' is quite quite intense'* (extract 5).

A potential problem of leaving a family alone may be that they are left simply waiting for the therapist to return. Although this was managed by orientations to the minimal amount of time taken (as shown earlier) and was also accounted for, it was also common for therapists to provide tasks to occupy the family during this period. These were either formal or informal and were taken up by the families with varying degrees of success. An example of an informal task was highlighted in extract 4 *'you can nip out and have a quick ciggie'*, which offered the family a brief activity to engage them until therapy resumed. More formal activities tended to be more therapeutically relevant. For example in extract 4 the therapist suggested they complete a list related to a problem-solving activity *'do you want me to leave you finishing off that list'*.

In ordinary conversations a standard solution to ending a sequence of talk is through a 'terminal sequence' (Schegloff and Sacks, 1973). Schegloff and Sacks show that for a terminal sequence to be successful the first speaker should initiate closure of the talk, which then obligates the recipient to respond in a way which communicates that the talk will close. In this first part of the paper we have shown that therapists used a number of conversational strategies to initiate closure and enable exit to consult the reflecting team: pre-announcement, minimising the amount of time taken, identifying/creating ERPs, and accounting for the departure. Additionally, tasks were sometimes assignedto be completed by family members in the therapist's absence. Typically these exit strategies tended to be successful in allowing the therapist to leave. Attempting exit however does pose some risk in terms of potentially precipitating therapeutic rupture. In therapeutic practice ruptures are desicrbed as a deterioration in the relationship between the therapist and client (Safran and Muran, 1996). This potential for rupture ws oriented to by therapists, displayed in the complex work undertaken to successfully achieve exit.

Performative action 2: Unsuccessful attempts to leave the room: potential for therapeutic rupture

In practice, leaving the room is not always successful. Success can be measured both in terms of achieving exit as well as in terms of maintaining therapeutic alliance with the familyIf therapists fail to manage the interruption successfully it can create a relationship ‘rupture’, which may then need to be repaired before a successful exit can be achieved. In ordinary conversation speakers use repair where there is a breach in the conversational rules as a way of maintaining social relations (Schegloff, 1992).

In family therapy the necessity for creating an interruption to speak to the reflecting team is integral to the process and therefore the inherent risks for rupture are particularly salient. This is further compounded by the nature of the multi-party interaction and thus the need to create a plan for managing such occurrences is essential. Our data revealed some cautionary lessons where the exit strategies discussed previously were not utilised effectively, and this resulted in rupture. Difficulties in successful therapy exits seemed to result from ineffectively creating an ERP, by not attending to appropriate timing and by not completing a ‘terminal sequence’.

Extract 6

Mum: Never talks about ↓it

Dad: Never spoke or said anythin’ except t’ the pe:ople who actually did the interviewin’ >at the time< (0.8) as far as ↑I know (.) ‘e ‘asn’t even told you has ‘e?

Mum: ↑No ‘e hasn’t told me ↓no

FT: ↑Right

Dad: So >you know what I mean< ‘e yer know

FT: I’m gonna take a few minutes t’ hear what Cara and Eve kind of are thinkin’ (.) and what (.) what they might have

Dad: See cuz Adam’s jus’ got ‘is compensation money

(Webber family session 1)

In the flow of the therapeutic conversation there may not be a naturally occurring ERP which the therapist can utilise, and this necessitates the therapist to create one. A naturally occurring ERP tends to be a space in the therapeutic conversation which occurs as one topic naturally concludes. There are occasions however where topics merge, and therefore a ‘transition relevant place’ for therapeutic interruption does not present itself. In these circumstances the therapist may attempt to close down or temporarily suspend the topic in order to consult with the reflecting team. In Extract 6 this did not

happen and thus resulted in an unsuccessful attempt to exit. Although the therapist used time minimisation and accounting for departure, even specifically naming the team *'Cara and Eve'*, the effectiveness was compromised because of limited attention to the need to 'pre-close' the topic . Schegloff and Sacks argue that for a successful pre-closure to occur the announcement of closure has to be augmented with a candidate resolution (Schegloff and Sacks, 1973). In extract 6, the therapist made a pre-closing announcement by drawing attention to his imminent exit, but failed to offer a candidate resolution such as offering to resume the topic on return. By way of comparison to this example where the therapist failed to initiate an ERP at an appropriate juncture in the conversation, in the following two extracts the therapist over-reache the ERP by continuing with his turn.

Extract 7

```
FT:        Okay (.) I ↑think what I'll do is I'll take <some time out> t' hear
           (.) what what Hannah and Dawn are thinkin' (.) ↑I guess one of the
           things I'm I'm
(1.4)
FT:        I mean we're talkin' 'bout bein' confused (.) one of the things I'm
           strugglin' with at the moment is kind of
(11.2)
FT:        what sort of things can we talk about
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(Clamp family session 10)

Extract 8

```
FT:        I'm gonna take some time >for a couple of minutes< jus' t' go an'
           hear their thoughts cuz ↑I'm kind of
(2.2)
Dad:       >we're doin' your head in basically< [heh [heh heh
Mum:                                                [heh he[h heh
FT:                                                        [↑No ↑you're ↑not
           ↑you're not doin' me in at a::ll .hh you're not doin' me in
```

(Niles family session 2)

In extract 7 the therapist continued past the obvious ERP that had been created 'to hear what Hannah and Dawn are thinking', by appending an additional topic-opening comment *'I guess one of the things I'm I'm'*. In extract 8 the therapist also overshot an appropriate ERP after 'to hear thei thoughts' and continued by qualifying his account *'cuz I'm kind of'*. The effect of over-riding the ERP in both cases was to re-open conversation, and invite additional comments from family members rather than provide a topic-terminal sequence that would close down further discussion. In doctor – patient interactions, research has shown that the professional and the client need to work collaboratively to

suspend the transition relevance of a possible turn completion, which requires both of them to understand this as the ending of the encounter (Robinson, 2001). Although both extracts 7 and 8 contain silences between utterances, these are mid-turn and are therefore not treated as topic terminations but are oriented to by the family members as pauses.

Self disclosure was also used in these two extracts as a way of accounting for the need to consult with the reflecting team. In extract 7 the therapist stated *‘one of the things I’m struggling with at the moment is kind of’* which notably tok 11 seconds to complete with *‘what sort of things we can talk about’*.

Typically self disclosure in therapeutic practice tends to be used as a device to elicit further contribution from family members. Its use at this juncture therefore is potentially at odds with any goal to suspend the conversation. Failure to complete the account in extract 8 functioned as an invitation for the father to provide a candidate account completion *‘we’re doing your head in basically’*. Although accompanied by laughter this turn was treated by the therapist as problematic. Research has shown that laughter in situations like this is a recognisable social action signalling that there is some trouble with what is being said (Jefferson, 1984). This potential trouble was attended to by the therapist who attempted to make a repair ‘*no you’re not, you’re not doing me in at all’*.

Extract 9

FT: I’m gonna go and speak to Kathryn for a moment .hh ↑oh thank you heh heh
Steve: Can I ↑come?
FT: ↓No I want you t’ stay ‘ere an’ <I want you t’ think about somethin’> an’ if you want t’ t’ even do it what I’m thinkin’ you’re cringin’ Sally and you’re worried about what I’m gonna say aren’t you? (0.4) I’m wonderin’ who (0.8) <I’m wonderin’ who> the two of you would most want t’ have a hug from

(Niles Family session 4)

In extract 9 the therapist’s exit attempt to speak to team member *‘Kathryn’* was compromised by the child’s request to accompany him. It has been established in previous research that ‘preferred’ responses to requests are compliance, and where a ‘dispreferred’, response is offered the speaker typically attends to this breach through an account or repair (Pomerantz, 1984). In this instance

Steve's request to go with the therapist to the reflecting team was denied, *'no I want you to stay 'ere'*. The potential for rupture created by this refusal was attended to by the therapist through the assignation of a task, which relates to the core therapeutic conversation previous to the exit attempt. This example highlights the utility of assigning formal therapy relevant tasks to families as a way of managing potential and actual rupture.

Performative action 3: Conveying the thoughts of the reflecting team: therapist re-entry

As with exiting therapy, re-entering the room also requires particular attention on the part of the therapist in order to both maintain the therapeutic alliance and to introduce the new material from the reflecting team. Our data suggest there are three key elements which contribute to successful re-entry: therapist's initiation of topic, attending to the reflecting team's comments, and revisiting the prior assigned task. Troublesome re-entry is marked by an absence of reference to the reflecting team or the prior task (where assigned).

Extract 10

```
FT:      ↑I guess they were noticin' that. we spent a lot of ↑time ta::lkin'
         about (.) Phillip and (.) Phillip bein' angry >an' a bit more today
         about other people bein' angry as well< (.) and kind of (.) what
         would it be ↑like (.) if that's different (.) if if Phillip isn't
         angry any more [w- w-
Dad:                    [I think it'd be a lot better (.) I do
Mum:     ↑Yeah
```

(Clamp family session 5)

Extract 11

```
FT:          [so (.) what we were wonderin' wuz t' see you two on yer own
         (0.2) in a couple of weeks ↑time
Gran:    Hu::m
FT:      erm (.) jus' t' get a <better>
Bob:     ↑Mummy
FT:      angle and view of how things are an' then in four weeks erm (.) and
         then in four weeks see all of you again = how do you feel about that?
Gran:    Well we were [just sayin'
Bob:                  [OH FAT BOLLOCKS
Gran:    He completely takes the who::le session ↑over
```

(Bremner family session 1)

These two extracts show three aspects of re-entry which contribute to successful realignment. First, n each case, the therapist took the first formal turn of talk to initiate a return to therapy relevant conversation. Second, he offered a formulation of the reflecting team's thoughts. Third, a positive

response was forthcoming from the family. In extract 10 through his use of footing (Goffman, 1981) i.e. his inclusive pronoun use ‘we’, the therapist aligned with the family *‘we spent a lot of time talking about Phillip’* and then proceeded to report the reflecting team’s observations about Phillip. In extract 11 the therapist aligned with the reflecting team ‘*what we were wondering’*, which conveyed his agreement with their suggestion to see the adults on their own. In both cases the family members were informed about the conversation between the therapist and the reflecting team, which offered a conclusion to the previous discussion. Notably, in both instances, uptake from the family members was positive. In extract 10 the father agreed that resolving Phillip’s anger would be *‘a lot better’,* and in extract 11 the proposal to meet with the adults separately was mutually arrived at as an acceptable solution: *‘we were just saying he completely takes the whole session over’*. In situations where the therapist has assigned a task for the family to compete prior to departure, he/she has the option of attending to this upon re-entry, prior to discussing the reflecting team’s comments.

Extract 12

FT: Er::m (.) did you get chance to think a↓bout that question o::r (.) did you jus’ ↓kind ↓of
Dad: ↑I can’t remember what it was n↑ow
FT: Relax for a bit? (.)
Mum: heh heh heh
FT: don’t worry about it (.) It was it it was ↑about (.) ↑I guess what you may have lea::rned from your dad about how t’ be a dad (1.2) er::m (.) but that is a very hard question >I know< you may need more time to think about it (1.0) Er::m (1.0) I’ll just I’ll just say a little bit about er::m (.) what I was talkin’ about with my (1.0) colleagues

(Clamp family session 3)

In this extract the therapist attended to the duality of both the task set for the family and the task of consulting the reflecting team *‘did you get a chance to think about’* and ‘*I’ll just say a little bit about what I was talking about’*. Here the therapist briefly mentioned the task he set the family, providing an opportunity for continuity between pre-and post exit. Importantly he provided the family with a mechanism for the possibility of failing to attend to the task in his absence by providing them with options *‘did you get chance to think about that question or did you just kind of … relax for a bit?’*. This appears t have successfully managed a potential rupture in two ways; by attending to the task it provided an opportunity for family members to show what they have achieved, and by providing a

method for non-compliance it maintainedthe therapeutic relationship. Focussing the family on talk about a previously set task however is not always a straightforward activity, as extract 13 illustrates.

Extract 13

FT: → Right before I see any more messages did anybody
Dad: That one’s alright look
Nic: hah hah hah
Steve: What what what
Dad; That’s the one with the two dogs
Steve: Oi oi
FT: → Any thoughts while I was out
Nic: Look that one
FT: I don’t want to see any more
Nic: That’s [alright look =
FT: [>I don’t want to see any more<
Nic: = that’s ↑alright (0.4) l o c k on the <‘phone please scanning> then it goes to that
Steve: Hah hah hah hah
FT: → They’re very clever heh heh any thoughts while I was out did you have anythin[g did you
Nic: [this one this one’s alright (.) you are the weakest link (.) goodbye
FT: Oh yeah that one
Steve: This one’s good
FT: → Did you have any thoughts while I was out?
Steve: Er::m no

(Niles family session 4)

Preceding the start of this extract were 95 lines of talk focused on the text messages on the children’s mobile (cell) telephones. The family members initiated this topic immediately upon the therapist’s return to the room giving them the conversational floor. When a current speaker is engaged in a particular topic, conversational rules typically limit the interactional rights of another party to change topic, which means that topic is necessarily then held off until it can occur naturally (Sacks and Schegloff, 1973). During extract 13 the therapist made a number of attempts to change topic and elicit a response from the family relating to the task previously set (marked by →). Notably the therapist unsuccessfully repeated the same phraseology *‘any thoughts while I was out’*. One explanation for being unsuccessful in the topic shift may be partially due to the use of the word’ *any’*, as evidence suggests that this phrase has a negative polarity and is more likely to prompt a ‘no’ response (Cohen-Cole, 1991; Heritage and Robinson, 2011). Eventually this ‘no’ response was acquired from Steve *‘erm no’* which ultimately signaled the closure of that topic. This turbulence in topic organisation

seems to indicate complexity in bringing in the thoughts of the reflecting team, and in this case the therapist made no further reference to his consultation with the team in this session. Non-reference to the reflecting team is not always due to the distraction of family members as illustrated by extract 13. Extracts 14 and 15 demonstrate that therapists may simply not attend to the conversation with the reflecting team and not report anything back to the family.

Extract 14

Dad: ↑Like I say you come up with <one thing> (0.4) >then like I say< you know like Mandy jus' says somethin' like well (0.2) what can you do with this or that or the other .hhh all ↑I can say is at the at the end of the day is remove him completely

Mum: Cuz you can't do that can you?

FT: And you don't want to?

Mum: Well no

FT: ↑Sure

(Webber family session 2)

Extract 15

FT: Hiya I'm aware of the (.) the time I ne::ed t' be er (.)

Dad: That's alright (.)

FT: to be quite brief

Dad: Plenty of time

FT: Can I ask very quickly (.) is there anythin' either of you want t' sa:::y (.) about to↑day

Dad: No not really

Mum: Not re:ally

Dad: I'd just like to know more about this if you could find out the information ↑like

(Clamp family session 10)

While both of these extracts illustrate troublesome re-entry for the therapist, they do differ in terms of alignment and potential rupture. Extract 14 highlights some potential trouble as the family members initiatedtopic immediately following the therapist's return to the room , thus limiting the space (and in this instance completely inhibiting any further opportunity) for the therapist to convey the discussion with the reflecting team back to them. As that topic was initiated by the father and continued from the preceding section of the therapy prior to the break, this potentially indicates a maintenance of therapeutic alliance and may suggest that therapeutic rupture had not occurred. In extract 15 however, despite the therapist taking the initial turn, therby creating an opportunity to feed back the reflecting teams' observations, he instead moved to close the session. Problematically, because the therapist reported not allowing enough time to reflect back with the family, it created what appears to be a

potential rupture not only within this particular session but perhaps also in the ongoing course of therapy. The subsequent conversational turns of the family suggested that they would appreciate further information by indicating that time was not a concern of theirs *'plenty of time'* and by requesting further feedback '*I'd just like to know more about this'*.

Discussion

The core objective of the reflecting team in family therapy is to free up a 'stuck system' by offering a range of alternative perspectives which will challenge and broaden restricted thinking (Andersen, 1987). The use of a reflecting team is considered to be an effective therapeutic modality as it enables new thoughts and questions to be highlighted that a therapist acting alone may not be aware of (Lax, 1989), and provides space for the emergence of new creative ideas (Andersen, 1987). Bringing in thoughts and comments from a reflecting team allows families a choice to accept or reject those ideas without damaging the relationship with the therapist (Smith *et al*., 1992). The effectiveness of the reflecting team however has a limited research evidence base (Willott *et al*., 2010). Thus, there is a risk that Andersen's vision of a more collaborative and reflective position in family therapy could be compromised in practice, without research into how therapists effectively integrate the suggestions from reflecting teams into the therapy (Brownlee et al, 2009). The rationale for this research was to explore in detail how therapists incorporate the comments, observations and suggestions from the reflective team, with a particular focus on the potential disruptions of the physical act of leaving and re-entering the therapuetic space.

Our findings illustrate that creating space for exiting therapy has potential for therapeutic rupture and therefore requires careful management. Similarly, to effectively integrate the thoughts and comments from the team upon re-entry requires a considered approach. Our data represent three fundamental performative actions related to how therapists manage exit from and re-entry into the therapy: first, the recognition/creation of an exit relevant place (ERP), second, challenges posed in exiting therapy, and

third, variability in conveying the reflecting team's thoughts upon re-entry. These are important given that the purpose of the reflecting team is to facilitate further discussion and provide different perspectives on the problem, which can help to mobilise the family towards more solution focussed thinking.

The first performative action illustrated that when a naturally occurring ERP was absent, the therapist worked to create one. They did this through conversational strategies such as pre-empting exit, minimisation of the length of time absent and discouraging further turns from family members. The second performative action highlighted the potential risk of rupture of therapeutic alliance at junctures where there were interruptions to the process of therapy when the therapist leaves the room. At points where there were therapeutic ruptures, therapists made attempts to repair which resulted in delayed exit. The third performative action related to the elements which contribute to successfulrelaying of information from the reflecting team and whether or not the therapist was able to integrate the reflecting team's contribution and reconnect with the family. On the basis of our analysis we propose three suggestions to help practitioners make more effective use of a reflecting team: specific techniques for pre-empting departure, strategies for recognising and creating ERPs and practical ways of managing re-entry which includes the reflecting team's contribution.

We have demonstrated that pre-empting departure is a helpful technique for facilitating successful exit. The data illustrate that drawing attention to the existence of the reflecting team and proposing later departure prepares the family for breaks in the therapeutic conversation. We suggest that this technique could be most effectively implemented if it were a regular feature of the initial part of sessions where the frame is being set up. During this initial framing therapists could give an indication of what point during the session that departure is likely to occur and why. This may help manage the family's expectations andserve as a reminder that the reflecting team exist, observing the family with

a view to offering a contribution. Just as consent should be an iterative process (O'Reilly *et al*., 2011), so also should reference to the reflecting team.

We further propose that pre-empting re-entry by indicating that the observations of the team will be discussed and the families' views on those comments will be sought prior to leaving will help the family understand the role of the reflecting team and engage with their comments. cCareful planning of the timing of exit to consult with the reflecting team is likely to enhance later exit and re-entry effectively. For example, our analysis of extract 15 demonstrated that the therapist did not leave enough time to allow for sharing the thoughts of the reflecting team with the family, or for eliciting their views and opinions. This therefore potentially invalidates the value of the team's contribution.

We have also demonstrated that there is a skill in both recognising and creating 'exit relevant places' (ERPs) in order to both manage the therapeutic alliance and create a space for the task of consulting the reflecting team. This involves a range of different strategies, including minimising the length of time absent, developing effective terminal sequences, and not over running the ERP. Linguistically and non-verbally 'effective terminal sequences' can be established by attention to closing down the topic and using closed rather than open utterances (Schegloff and Sacks, 1973). White et al (1994) found that in the vast majority of visits to the doctor, it was the doctor who initiated the closing of the session with patients generally displaying agreement with that closure. This also seems to be the case for temporary closing within sessions, for example, non-verbally the therapist may stand at an ERP and indicate leaving the therapy, or verbally could ensure that sentences are completed with final intonation and no invitation for further contribution. Furthermore, over-running an ERP is likely to delay exit and invite an opportunity for further topic discussion rather than closing down the current topic. In practice this means that when an ERP is created or occurs naturally, if the therapist does not attend to this opportunity and continues speaking it is likely to encourage family members to continue engaging and the opportunity to leave may be lost.

Finally, we have demonstrated that successful re-entry into therapy can be hindered by insufficient attention to either previously assigned tasks or to the reflecting team's comments. We therefore recommend that if a task has been assigned prior to the exit, then this ought to be attended to upon re-entry so as to enhance continuity and recognise the potential effort given by family members to that task. This is particularly important if the task set had some therapeutic relevance. The requirement to re-visit the task upon re-entry should be a consideration borne in mind by therapists setting tasks to facilitate exit.

Notably, the potential rupture caused by exit to consult the reflecting team is necessitated due to the anticipated benefits of utilising those comments. Our data highlighted however that these benefits are not always realised in practice due to a number of factors which seem to prohibit inclusion. We suggest, therefore, that therapists are mindful of three main issues relating to the difficulty of integrating the reflecting team's comments usefully. First, planning the timing related to the point in therapy suitable for exit is important, by taking into account the amount of time needed to reflect back the team's comments and for the family to share their thoughts. Leaving the exit quite late in the session may jeopardise this opportunity. Second, the intention of the therapist should be to make the team's comments a priority upon re-entry. If it is not, there is a risk that the family will for various reasons move the conversation in a different direction. This may be because they are unaware that they are privileged to have that information, or anxiety may be evoked creating avoidance of the potential issues raised. Third, in order to manage this potential turbulence, re-entry is facilitated by therapist initiation of conversation. Where therapists re-enter the room immediately take the conversational floor, the success of integrating the reflecting team's comments is more likely.

Using a conversation analytic framework the analyst is able to explore the sequential process of healthcare interactions in order to ascertain how these are achieved in a moment-by-moment way

(Heritage and Maynard, 2006; Heritage and Robinson, 2006). This approach has been useful in elucidating the nuances of the therapeutic process and instances of exiting therapy for the purpose of consulting a reflecting team. Ostensibly the small sample size of two therapists and four families may limit the transferability of findings to other settings, and yet this corpus has provided rich detail and allows for some useful lessons for practitioners in the field. This is done in recognition of the contemporary trend towards making CA more applied (Antaki 2011)

The literature on reflecting teams acknowledges that more research into the process and efficacy of this resource is essential, and that it is important to ask questions about not only therapeutic outcomes but also the less visible *processes* used by therapists (Willott *et al*., 2010). This paper goes some way to addressing this important issue but it is clear that a stronger empirical evidence base regarding the use of reflecting teams in family therapy is essential to inform best practice. One area which may warrant further attention within this field is that of the way that children make contributions. This paper indicates that children do make contributions surrounding exit and re-entry sequences, but the literature suggests that family sessions involvingreflecting teams tend to favour the adults which risks marginalising the child (Fredman *et al*., 2007).

In conclusion, we have presented an argument that within the context of using a reflective team in family therapy, therapists need to attend to the details of disengagement and re-engagement with the therapeutic conversation necessitated by leaving and re-etnering the room to consult with the reflecting team.   Analysis of our data reveals some specific ways in which therapists can maintain therapeutic alliance with families, despite the potential rupture that may be incurred during the interruption to consult with the team. Additionally, the opportunity to sequentially examine the unfolding details of clinical practice in this way has allowed us to explore the nuances of what actually happens during exit and re-entry junctures in order to consider how the development of these skills can lead to greater efficacy of clinical practice.. This benchmark study hopefully simulates

further interest in examining the actual use of reflecting teams and provides a basis for the development of more outcome-measure based research.

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