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Karl Tomm's Internalized Other Interviewing: From Theory to Practice

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Karl Tomm's Internalized Other Interviewing: From Theory to Practice

by

Robin Akdeniz

A Dissertation Presented to the

Dr. Kiran C. Patel College of Osteopathic Medicine

In Partial Fulfillment of the Requirements for the Degree of

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This dissertation was submitted by Robin Akdeniz under the direction of the chair of the dissertation committee listed below. It was submitted to the Dr. Kiran C. Patel College of Osteopathic Medicine and approved in partial fulfillment of the requirements for the degree of Philosophy in the Department of Family Therapy at Nova Southeastern University.

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Acknowledgments

It is with immense gratitude that I bring this work to fruition and acknowledge those who contributed to this moment in my life. As I thank the many people who have been a vital part of my scholastic and professional journey, culminating in this dissertation, I pay homage to my community of internalized others—whom I recognize below—as well as those who are no longer with me physically but have made distinct contributions to my evolution.

I am eternally grateful to have had the opportunity to learn from my chair and mentor, Douglas Flemons. From helping me contemplate how mind works, to assisting my development of a meditative practice and enhancing my relational understanding through hypnotherapy, he has influenced me profoundly. As a student and supervisor assistant, I acknowledge and thank him for the knowledge, expertise, and wisdom he has shared, which opened horizons for me that I never knew existed. I am grateful for his mentorship as a gifted teacher throughout my time in the Ph.D. program, as well as for the opportunity to have him as my chair. He fostered my growth through all the twists, turns, and various iterations of this dissertation process, and I deeply appreciate the meticulous care with which he guided me. His constant support, extraordinary thoughtfulness, and confidence in my abilities helped me arrive at this place. As he both challenged and encouraged me, he remained committed to the ideas in this manuscript and believed in my scholarly ability to bring forth Karl Tomm's internalized other interviewing (IOI) approach.

As a student, my knowledge of Karl Tomm and his contributions to the field of family therapy arose from assigned course readings, most notably his articles about the

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Milan team, circularity, reflexivity, and interventive interviewing. In the process of developing a dissertation topic, I encountered Tomm's practice of IOI and was immediately fascinated. I could not have imagined then that I would eventually have this exceptional opportunity to learn about Tomm's systemic approach to clinical practice, particularly his practice of IOI.

This dissertation might not have been possible if I had not been given the opportunity to travel to Calgary and participate in an externship at the Calgary Family Therapy Centre. That transformative experience offered me the chance to learn directly from Karl Tomm, observing him practice his unique way of interviewing families and discovering the intricacies of the theory and practice of IOI. It has been a supreme privilege and honor to meet Karl, to be accepted to participate in the externship, and to observe his elegant work. I extend my gratitude to him for not only permitting me to study his work, but for enthusiastically supporting my work and making himself available throughout this process. I am grateful for our enlivened conversations, in which he encouraged me to step more deeply into this practice and sparked my inspiration to explore this profoundly rich way of working with clients.

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on a long journey through the history of post-modern family therapy, and for her valuable feedback. All of her contributions inspired the generation of many possibilities, which I refer to in the final chapter of this dissertation. My appreciation extends to Kara for stepping in to join my committee and support this work. Her suggestions inspired me to elevate my writing to a higher standard, ensuring that I produced scholarly work that honors greater inclusivity and social justice.

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focused therapy. This would forever change my way of understanding my clients; it is a shift for which I am eternally grateful. I am thankful to J.J. for promoting my leadership in the MSW program and encouraging me to go after my dreams, which inspired my pursuit of this doctoral degree. I am forever grateful to J. J. for showing me that hope is powerful and miracles abound.

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throughout this process. I thank them for their patience, tolerance, humor, and kindness, and for nurturing me with food and sustenance when they intuited my needs. I am eternally thankful to have taken this journey with them both by my side.

Lastly, I extend great appreciation to my editor, Denise, whose talent and careful attention to detail I truly admire. I am grateful for her scrupulous examination of my every word and her ability to transform them into a manuscript that speaks with clarity and intention.

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Abstract

Over the last 40 years, the Canadian psychiatrist and family therapist Karl Tomm has

been a key contributor to postmodern developments in family therapy (Collins & Tomm,

2009; Strong et al., 2008; Tomm, Hoyt, & Madigan, 2001). This dissertation traces the

people, ideas, and practices that have influenced Tomm's approach, providing an in-

depth examination of the method he developed for putting his ideas into practice:

Internalized Other Interviewing (IOI).

A systemic, relational approach to the practice of postmodern family therapy uses

language as a means to create change. Family therapists routinely use different types of

questions to ask clients about other people in their lives. Direct, information-seeking

questions privilege objectivity, whereas interpersonal perception questions privilege

subjective assumptions and allow for new possibilities to arise. The IOI approach offers a

third way to ask questions that "privilege subject-dependent assumptions and embodied

knowledge" (K. Tomm, personal communication, August 15, 2019). By inviting clients

to speak from their *experience* of the other, therapists gain entry to a broader base of

knowledge.

Grounded in social constructionism and bringforthism (Strong et al., 2008;

Tomm, 1999, 2002, 2014b), IOI has remained relatively unrecognized and underutilized

in clinical work. To date, the theoretical underpinnings and historical development of IOI

have not been thoroughly delineated. This dissertation provides the necessary background

information and detailed examples for therapists to put the practice in context.

Archival information about case examples collected during and following the author's

externship at the Calgary Family Therapy Centre in August 2019 have been interwoven

throughout the manuscript. These case descriptions, along with Karl Tomm's reflective thoughts, are used to illustrate and illuminate the theory and practice of IOI, bringing to life Tomm's inimitable way of working systemically with individuals, couples, and families.

A Note on Confidentiality

I present several clinical cases in this dissertation. To protect the confidentiality of the

clients I mention, I have altered all names and identifying details.

Part One: The Foundations of Internalized Other Interviewing

CHAPTER I: INTRODUCTION

If we only look at the individual skin-bounded, separate individual, we're very limited to what we can do. And so my hope is that you can get to see things more systemically.

—*Karl Tomm* (personal communication, August 13, 2019)

After seeing a family—a mother, her husband, and her two adolescent daughters—at the Calgary Family Therapy Centre (CFTC) for a number of sessions, a therapist learned that the older sister, Sophie, had recently beat up her younger sister, Susie, so badly that Susie required a hospital visit and several sutures. The therapist asked Dr. Karl Tomm, the director of the center, to join her for the family's next session, and he agreed to participate. At the appointed time, only the mother, Lisa, arrived for the session. The daughters declined to attend, stating that they were too embarrassed. Lisa's husband, thinking it no longer useful to participate without the girls present, also chose not to be there.

Dr. Tomm and the therapist sat facing Lisa. After the therapist briefed him about the family's progress in therapy, Dr. Tomm asked Lisa what had been helpful in therapy so far and what she would like to work on in that session. Lisa stated that she wanted to have a better relationship with her daughter, Sophie. Sitting across from Lisa with his fingers clasped and his forearms resting on his knees, Dr. Tomm (KT) leaned in and asked her if she would like to have a different sort of conversation—one that invited her to speak about Sophie's experience, from Sophie's perspective.

The scene just described was a previously recorded session that my colleagues and I watched with rapt attention, eyes wide and completely transfixed. As we watched

the session unfold, we saw Dr. Tomm speak to Lisa, addressing her as Sophie and repeating the name frequently throughout the conversation:

KT: So, Sophie, you feel like you're in competition with Susie?

L: Yes.

KT: When you were growing up, with your mom and your sister, did you have a sense that your mom tried to treat you and Susie the same, Sophie? . . . Or did you get a sense that she had a different relationship with each of you?

L: She tried to treat us the same.

KT: Would you prefer that your mom tried to treat you and Susie . . . you know, equally, . . . or would you rather your mom tried to create unique and different relationships with . . . each of you? What would you prefer, Sophie?

L: Unique and different.

KT: What . . . do you see as most unique about your relationship with your mom?

L: My mom and I talk about more things than she and Susie talk about. . . . Susie kind of keeps to herself. But mom and I are closer.

KT: More openness. What else do you see, Sophie, as quite unique in your relationship with your mom? Besides this openness and being able to share personal things? What do you think your mom likes about you as a person?

L: She says that she likes spending time with me. She enjoys my company.

KT: I'm curious what would you imagine she likes about you in terms of your personality and the way you are, as a human being, as a young woman? What do you think that your mom feels warmly about?

L: I don't think she does feel warmly.

KT: Do you feel warmly about your mom?

L: Yes.

KT: What do you like about your mom?

L: She doesn't hold a grudge.

KT: Ok. You appreciate that. What else do you like about her?

L: She loves me . . . if I need something, she tries to help me get it done . . . she encourages me

KT: She's encouraging, she's helpful. Hmm. Are you the kind of person who finds it easy to express her appreciation and gratitude, like when someone is helpful and . . .

L: Not really.

KT: What holds you back from doing that . . . like to tell your mom how much you appreciate her love and helpfulness. What holds you back from that, Sophie? (Lisa starts to cry)

KT: Is that Sophie's sadness, or is that Lisa's sadness coming up? . . . Is it because you sort of miss that appreciation from her? Acknowledgement of your . . .

L: She doesn't do that anymore.

KT: So that hurts. Does she respond to your hug by accepting it?

L: Sometimes, and sometimes not. (cries) That hurts my feelings.[1]

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[1] It is of particular importance, for ethical practice, to maintain an awareness of and acknowledge the potential for inadvertent subjugation, oppression, and the influence of power hierarchies in any therapeutic interaction. In presenting this case, Dr. Tomm emphasized the importance of being grounded in systemic work prior to engaging in an interaction such as this with clients, noting this way of working to be a practice rather than merely a technique (K. Tomm, personal communication, August 15, 2019). It is essential for therapists to be aware of the choices they make during all therapeutic interactions regarding when and with whom they choose to interview in this way. I will address this issue in more detail in Chapters II, V, and VIII.

Prior to the next session, Lisa called to cancel. In a follow-up conversation with Dr. Tomm, she reported that after her conversation with him, she had taken her daughter, Sophie, out for coffee, during which time they talked about the session. Sophie asked Lisa about the interview and what had transpired. She "was amazed at how well her mother understood her . . . that Sophie didn't think that her mother understood what was relevant for her" (K. Tomm, personal communication, August 15, 2019). Tomm explained that "this led to a very significant clarifying conversation and increased openness between [Lisa and Sophie], which then spilled over into the relationship between Sophie and Susie . . . then between both girls and [their father]. So, everybody in the family system sort of moved into a new place. [The interview] triggered this kind of shift . . . [; it] had a really profound effect on the relational dynamics of the actual system. This was the end of therapy, basically, for this course" (personal communication).

This unusual way of having a therapeutic conversation is a practice Karl Tomm calls *internalized other interviewing* (IOI). This dissertation is devoted to making sense of this unique interviewing practice, which Tomm has developed and used over the past 30 years, in a variety of ways and in different contexts. Though he has taught and talked about the approach in workshops and trainings, he has written very little about it.

This dissertation will explore IOI, as developed by Dr. Karl Tomm, a Canadian psychiatrist and family therapist who, over the last 40 years, has significantly influenced, shaped, and contributed to the field of family therapy. The IOI approach is just one of the many novel ideas and practices Tomm has developed. In Part One of the dissertation, I place him in historical context, detailing the philosophical, ethical, theoretical, and therapeutic *foundations* of IOI. In Part Two, I explore the *practice* of IOI, situating it in

context by first describing it and then comparing it to ostensibly similar practices in other traditions and models. I then discuss variations in its application with a range of populations. I illustrate and deepen this discussion with case examples drawn from a two-week externship training I attended at the Calgary Family Therapy Centre (CFTC) in August 2019, from video recordings of IOI sessions I studied when in Calgary, and from in-depth follow-up conversations I recorded with Dr. Tomm in the spring of 2020.[2] Throughout the dissertation, my aim is to ground, broaden, and nuance an understanding of IOI. Part Two ends with a discussion of implications, not only for the field of family therapy, but also for other professions, contexts, and systems.

Karl Tomm and the Field of Family Therapy

Tomm's work and the development of IOI can best be understood through the context of his personal and professional development. His evolution reflected the evolution of the field, from a modern and lineal perspective to one of circularity and systemic thinking. He continually attended to the inherent risks of assuming a worldview or paradigm as an objective truth, as well as to the responsibility we must assume as to acknowledge our power to privilege one idea over another. Tomm noticed changes occurring in his "personal belief system about the nature of knowledge and of therapy" (Collins & Tomm, 2009, p. 109). By shifting paradigms, from his initial training in "empiricism and objectivity . . . [to] the domain of constructing alternative knowledges that are not based on objectivity," (p. 109) Tomm was led to "constructivism, social constructionism, and eventually [Humberto Maturana's notion of] bringforthism" (Collins & Tomm, 2009, p. 109)—philosophical developments that are discussed in

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[2] My university's Institutional Review Board determined that this theoretical dissertation did not require review (see Appendix A).

Chapter III. He described this as "the single most significant change that occurred in [his] professional development . . . [noting that it enabled him to] liberate [him]self from the empirical paradigm so [he] could move into a social constructionist or a bringforthist paradigm when . . . doing clinical work" (p. 109).

From his earliest exposure and interest in general systems theory, to his work with Bateson's concepts of circularity, cybernetics, interaction, and "mind," Tomm continuously developed new understandings of his clinical work. Over time, he gravitated toward social constructionism and the framework upon which his current work is situated. The coordinated management of meaning (CMM), a theory Tomm found useful, which conceptualized communication as circular and interactive, thereby affecting change in the construction of meaning and reality, provided Tomm with context regarding his ideas about reflexivity, meaning, and the process of change.

According to Tomm (2014b), "the most comprehensive and satisfying explanation for human existence and awareness that I have come across (to date) has been Maturana's theory of cognition" (p. 234). Tomm derived his understanding of Maturana by reading his works, exploring his concepts, and speaking with him on multiple occasions. His family, as well as his research associates, both in Calgary and other locations around the globe, informed Tomm's work and provided a foundation for his epistemological stance (K. Tomm, personal communication, August 16, 2019). With further refinement and enrichment from his own colleagues and students, he developed what he considers a *bringforthist paradigm* for clinical practice, which he defines as a "rigorous constellation of concepts, values, perceptions, and practices shared by a community which informs a

particular version of reality and which becomes a basis for the way in which a community organizes itself" (K. Tomm, personal communication, August 16, 2019).

To describe how Maturana's theory made sense to him, Tomm recalls a statement Maturana made at the beginning of one of his lectures: "We find ourselves here in the happening of living; talking and drawing distinctions in our experiences . . . [a statement that explains] how each one of us as an individual human being arises at a unique intersection of two gigantic processes of drift in structure determined interaction" (Tomm, 2014b, p. 234). He goes on to explain that one process is the "millennia of phylogenetic drifting . . . culminating in each person's unique genetic heritage and biological make-up in the molecular space" (pp. 234-235), while the other process involves "the increasingly coordinated conduct among plastic living systems to generate complex ecologies and ultimately a huge socio-cultural drift in the interpersonal space" (p. 235). Here, in this drift, "we, as cognizing living systems, are structure determined to become aware, conscious, and free to talk, draw distinctions, and make choices in our daily living" (p. 235). A critical aspect of this socio-cultural drift is "the emergence of language . . . define[d] recursively as 'the consensual coordination, of the consensual coordination, of conduct' (H. Maturana, personal communication, January 21, 1987)" (p. 235). The consensual coordinations Maturana spoke of "reflect relational stabilities that arise in the interpersonal (social) space" (p. 235).

Understanding language as "not in the brain [but] among us as languaging living systems" (Tomm, 2014b, p. 235) locates it as primarily social and then "secondarily internalized through memory to become psychological, where it supports intrapersonal reflection and thinking" (p. 235). Maturana's ideas make it:

easier to become skeptical about the reality of our experience as separate individual selves. Our separateness can then more readily be recognized and acknowledged as a functional illusion—a realization that allows us to embrace relational understandings more fully. Our individual characteristics, whether they are positive or negative, may then be understood as concatenated end points of a huge process of interactive drifting, including long histories of dynamic patterns of interpersonal interaction. (Tomm, 2014b, pp. 235-236)

Conceptualizing language in this way helped construct the foundation upon which Tomm would apply a theoretical framework for his evolving clinical work.

Tomm is "known both as an original thinker and as an integrator and explicator of key developments in the . . . field of family therapy and social constructionist theory" (Tomm, Hoyt, & Madigan, 2001, p. 245). Through his teachings and contributions, in both writings and presentations, he demonstrates a "special sensitivity to interactional processes in the roles of the family therapist, the ethics of therapeutic discourses and practices, and the social/systemic construction of the self" (Tomm, et al., 2001, p. 245).

One of Tomm's most significant contributions to the field emerged from his interest in and commitment to practicing ethically. He routinely explored and reflected on his own power and privilege, his experiences of injustice within families and communities, and the influence of cultural discourses. Through these reflections, he came to formulate new understandings about what it means to collude with, be complicit in, acknowledge, assume responsibility for, and challenge oppressive practices in one's professional work. Tomm (2014b) posited that "as therapists, [we should] try to live congruently and prevent or reduce injustice whenever we can, both inside and outside of

therapy" (p. 239). He emphasized the importance of paying attention to not only the more obvious and explicit injustices, but also the many "subtle, social domains where we could help reduce and/or avert unnecessary injustice and trauma on an almost daily basis" (p. 239). Such ethical commitments led Tomm to develop a framework of postures for therapists to assume with their clients that are grounded in principles such as empowerment, respect, and love. His evolving epistemological stance transformed alongside the development of the field of family therapy. As he was influenced by ideas from the field, so was the field influenced by his contributions. This process of co-evolution shifted the philosophical foundation upon which Tomm established his relational, systemic work.

Regarded as having an ability to sense "what's current and to embrace new ideas" (Tomm et al., 2001, p. 247), Tomm is known by other leaders in the field as an innovator and seeker of knowledge. Over the years, he invited many well-regarded practitioners and theorists to his program at the CFTC, including the Milan team, Maturana, and Michael White. He has been recognized as someone who is willing to stand up to criticism and assume difficult positions that serve to benefit others. He is respected "as a person in terms of [his] ethics and integrity . . . as a rebel that will speak to very difficult issues . . . and [as] the man with the very good nose that . . . brought a tremendous amount of theory and talent to North America" (Tomm et al., 2001, p. 248).

As Tomm continued to shift his assumptions and explore new ideas, he encountered, was influenced by, and contributed to various therapeutic approaches and models that he incorporated into his own therapeutic practice. Learning from the Milan team fostered his shift from empiricism to constructivism and led him to modify his

perspective, from viewing families as homeostatic to seeing them as constantly changing. His interest in the Milan approach increased his understanding about the effects of context on behaviors and meaning and the location of problems in the interactional space between people. This exposure inspired him to develop new techniques that serve to enable the development of alternative interactional patterns.

During this period of Tomm's professional development, his personal stance—along with the general stance within the field of family therapy—began to transition from first to second-order cybernetics. Accordingly, he began exploring ideas and collaborating with other clinicians to further develop the concepts of circularity and reflexivity, as well as to investigate how certain questions affect clients. Additionally, he continued to expand his evolving ideas regarding the therapeutic relationship and the role of the therapist. Tomm was significantly impacted by the Milan team's use of paradox, which he saw as a way of creating confusion around beliefs families held firmly to, thereby opening space to consider and create new beliefs and patterns. The technique of positive connotation was an extremely powerful discovery for Tomm. He incorporated it into his clinical work, along with the prescription of family rituals. The Milan five-part interview, which he wrote about in extensive detail (Tomm, 1984b), continues to impact his and his colleague's present-day use of pre-sessions and teams.

The work of Tom Andersen (1987)—particularly the use of reflecting teams as observing, participatory, and generative of therapeutic change—had a profound impact on Tomm and became a major facet of clinical practice at the CFTC. Informed by Andersen's work, Tomm's clinical team shifted its focus from privileging the team to focusing on and privileging the family. Anderson and Goolishian's collaborative

language systems therapy also contributed to this shift. Tomm and his team were informed by the practices of embracing the client's expertise, utilizing conversation to generate alternative realities that could build upon ideas of wellness and competence, and focusing on strengths rather than deficits (Tomm, 1998a). In addition, Tomm was influenced by the solution-focused brief therapy (SFBT) approach, which helped him shift his focus from problems to solutions and facilitate change in the direction of wellness.

The narrative therapy approach, pioneered by Michael White, focuses on the *influence* of the problem; this represents a departure from the Milan team's focus on the *function* of the problem. Tomm (1989, 1993) found tremendous value in various aspects of White's work, particularly the technique of externalization, which he considered a major advancement in the field of psychotherapy. Conceptualizing the problem as external relocated it from inside the person to outside as a separate entity, thereby transforming it from an oppressive and constraining entity to one that freed the person to consider possibilities. Tomm's work was also impacted by White's focus—inspired by the work of Michael Foucault—on injustice and the oppressive effects of power, as well as his commitment to protest against dominant discourses that constrain. Tomm (1993) saw this as a process of deconstruction, bifurcation, and reconstruction. For him, resistance to restrictive dominant discourses served to deconstruct subjugated descriptions of individuals that, once externalized, can foster a sense of personal agency. As Tomm explored these ideas, he came to understand narrative therapy through the lens of Maturana's work, understanding both pathologizing and healthy interpersonal patterns of interaction as *mutual invitations*.

Tomm is committed to practicing ethically and respectfully in his work, which includes training, teaching, and supervising clinicians; collaborating with clinical teams; working with reflecting teams; and conducting research. This ethical position is exemplified in the clinical program he and his colleagues developed at the CFTC (Tomm, 2014a). As director of the CFTC, Tomm (1990, 1991, 2014a) was faced with a challenge. To satisfy the administrators of the medical school, he was required to provide diagnoses for his clients. However, he maintained a commitment to avoid subjugating or pathologizing his clients through oppressive labeling practices. In response to this challenge, Tomm began to work on devising an assessment method that would serve as an alternative to the DSM and help him avoid undermining his postmodern and systemic commitments. The result was what he called the *IPscope*; it serves as a way of conceptualizing and assessing both pathologizing and healthy interactional patterns. Recognizing that "family relationships are probably the most complex and intense relationships that people have in their lifetime" (Denborough & Tomm, 2001, p. 117), Tomm focused on patterns of interaction within these relationships, thereby "validat[ing] the importance of the human experience of relatedness and connectedness" (p. 117). His underlying belief was that "we, as persons, invite each other into recurrent patterns of interaction that generate and maintain some stability in our continuously changing relationships. . . . These transient relational stabilities can have major positive or negative effects in our lives" (Tomm, 2014a, p. 1).

Tomm (2014b) found himself "becoming energized by the possibilities that arise when . . . look[ing] at the world through the lens of the IPscope" (p. 229), which is discussed in greater depth in Chapter V. As an assessment tool, as a way to conceptualize

interpersonal patterns, and as a way of training students in systemic understanding, the IPscope offers many possibilities for clinical work and future developments. It characterizes patterns of interaction as pathologizing (PIPs), healthy (HIPs), transformational (TIPs) in the direction of wellness (WIPs), or deteriorating (DIPs) (Tomm, 2014c). It also makes it possible to acknowledge the influence of socio-cultural patterns (SCIPs) and indicate whether they restrain or support individuals. A unique contribution to the field of family therapy, the IPscope counters "the taken-for-granted power of pervasive habits of seeing persons as individuals and helps limit the subterranean exuberance of rampant individualism in our Western culture" (Tomm, 2014b, p. 231).

Building upon concepts from Bateson, Maturana, the Milan team, and CMM theory, Tomm (1987a, 1987b, 1988) wrote a number of articles about the use of questions in therapeutic interviews. He distinguished the use of questions from the practice of merely gaining information through assessments or other instruments. Tomm underscored the interventive effect that questions have on clients and introduced an approach to questioning called *interventive interviewing*, which I will elaborate on in Chapter V. Tomm distinguished between lineal, circular, strategic, and reflexive questions, discussing them in terms of the therapist's orientation and intentions, and detailing their effect on the therapeutic relationship. Recently, Tomm collaborated with Hornstrop (K. Tomm, personal communication, August 14, 2019) to designate four categories of questions: situation clarifying, relational embeddedness, initiatives clarifying, or possibility generating. However, Tomm explains that the original and

widely used framework of questions is recommended for those who are learning systemic practice.

Working from a social constructionist and bringforthist stance, Tomm (1999; 2002; personal communication, August 15, 2019) has developed ways of working with families that enable the deconstructing of shame and guilt, open space for apology and forgiveness, and co-construct hope and responsibility. These are reviewed in detail in Chapter VI.

Karl Tomm's Practice of Internalized Other Interviewing

The foundational ideas explicated in Part One serve to contextualize Part Two, which describes the *practice* of IOI. There, I describe the clinical aspects of IOI, detailing its variations, implications, and limitations. I also incorporate information that I obtained from the two-week CFTC externship I attended, as well as from recorded follow-up conversations with Karl Tomm. Much of this information is introduced in the form of clinical stories and examples that help illuminate various aspects of both theory and practice. I reference cases that the externship instructors presented as demonstrations, as well as cases depicted in CFTC videotapes that I viewed and took extensive notes on while in Calgary.

In Chapter VII, I explore IOI contextually, describing the practice and identifying resonances and juxtapositions with other seemingly similar practices, such as those found in the Gestalt therapy, Psychodrama, and Internal Family Systems approaches. Looking at IOI in its historical context, I begin with an early iteration of the practice, written about by David Epston, who co-developed narrative therapy with Michael White. I explore the ways in which Tomm, guided by his evolving philosophical and theoretical assumptions,

developed IOI into a practice with purpose and intent. Tomm has yet to elaborate upon his approach, and little has been written about it; however, two research studies of IOI, one quantitative and one qualitative, have been conducted on the practice. They are described in this chapter.

In Part Two, Chapter VIII, I shift from discussing the broader contextual aspects of IOI to focusing on the practice. I demonstrate how, through IOI, "systemic therapy can be 'smuggled' past the 'skin-bounded self' to work with individuals systemically" (K. Tomm, personal communication, August 15, 2019). I make the case that IOI fits within the paradigms of social constructionism and bringforthism, which frame the recognition that as we go together in life, in our relationships, through our shared language and shared experiences, we come to develop our own understandings of others, which inform our "knowing" and ways of understanding our relationships and ourselves. They are a part of us and have contributed to who we are and have become. They are our *internalized others*. The IOI approach makes it possible for clinicians to work systemically and relationally with individual clients, inviting them to speak from the perspective and experience of their internalized others, thereby bringing those relationships into the therapy room.

Tomm (2014b) describes IOI as a "pragmatic application of . . . how our psychological selves arise through social interaction [using] a unique pattern of therapeutic interviewing" (p. 236). He defines the practice as "a unique method of systemic interviewing that may be employed for the purpose of influencing clients towards change by bringing forth and perturbing previously internalized patterns of interaction with others" (K. Tomm, personal communication, August 15, 2019). The

practice, described in detail in Chapter VIII, involves asking the internalized other questions that elicit the bringing forth of pathologizing problems that were previously internalized. Once externalized, they become available for deconstruction, enabling the activation of healing patterns.

Sometimes Tomm interviews the internalized other with the actual other in the room. The actual other thus "comes to meet an aspect of himself or herself that exists in the client being so interviewed" (Tomm, 2014b, p. 238). This *distributed* self resides within the other (Tomm, 2014b). Tomm interviews both the internalized other and the distributed self "to stimulate curiosity and understanding of others' experiences, generate empathy, focus attention on the other, correct erroneous beliefs, and invite changes in relationships" (Moules, 2010, p. 188). As discussed in Chapter VIII, this way of interviewing can be expanded and applied in a variety of ways. For example, just as an internalized person can be interviewed, so can an emotion, belief, stereotype, bias, problem, idea, or concept. Special considerations, limitations, and contraindications of interviewing in this way will be discussed in later chapters. In Chapter IX, I describe how IOI can be used in the training of new therapists and incorporated with a variety of populations, including violent men, children exposed to violence, people whose significant others are not present, and grieving individuals. In Chapter X, I discuss the implications of the theory and practice of Karl Tomm's IOI, exploring possibilities for the field of family therapy identifying potential applications in contexts outside of family therapy, and exploring ideas for future research.

Rationale for and History of This Exploration

In the bringforthist paradigm, the ontological assumption is that there are multiple realities; "each reality is that which the observer is structure determined to bring forth as 'real' in his or her living" (K. Tomm, personal communication, August 16, 2019). The social constructionist assumption is relativist. In other words, it presupposes that "realities exist in the form of multiple constructions [that are] socially and experientially based . . . [and are] dependent on social consensus within the communities in which they arise" (K. Tomm, personal communication, August 16, 2019). These paradigms and their assumptions serve as a theoretical foundation for IOI. The foundations and practice of this special interviewing method that Tomm developed are the central focus of the present dissertation study.

To explore this practice, I initially considered the idea of undertaking a qualitative research study to explore the experience and meaning of IOI from participant perspectives. However, once I began immersing myself in the literature, specifically in the philosophical assumptions and the theoretical and therapeutic inspirations informing IOI, it became clear to me that an in-depth research investigation would be premature. A preliminary step was necessary. My dissertation chair and I determined that I should conduct a comprehensive investigation of the theory and practice of IOI, laying a firm orienting foundation for other scholars to launch subsequent explorations.

Before examining the foundations of IOI in Part One, I will first contextualize this project by addressing how I found my way into this area of study. Many of the influences that affected Karl Tomm's evolution resonate strongly with me, as I have had similar experiences that impacted my personal journey. My reality has been construed through

my experiences as a White, middle-class, heterosexual female. Studying occupational therapy in pursuit of my bachelor's degree, I took for granted the notion of objective truth from a modernist perspective. Working as a hand therapist, what mattered most was my objective assessment of my patients' functioning, the implementation of therapy practices to improve their functioning, and re-evaluation through measurements that assess progress. The conversations I had with my patients were from the position of expert, and my communications with, and about, them were focused on so-called objective data.

Many personal life experiences influenced me as well, informing my view of human relationships and the world in general. From my intercultural/interfaith marriage, I developed a more expansive perspective. My husband and I spent years struggling to have a biological child—years that were full of momentary joys and disappointments. We had experiences with international adoption and raising our two daughters overseas, and then experiences with cancer and treatment, and then cancer again. Each of these experiences brought a renewed appreciation for life and a desire to give back to the world in some meaningful way. Years later, I enrolled in an MSW program, where I gathered an array of tools and skills, preparing to work with clients as a clinical social worker. Once again, the majority of what I learned was taught from a predominantly modernist perspective; however, I took an elective in solution-focused therapy, which offered me my first encounter with post-modern ideas and the theory of social constructionism.

My interest in exploring IOI seems to parallel the shift I experienced when I began to further expand my understanding of human behavior through a systemic and relationship-oriented lens. As I continued my training and went on to pursue a doctoral degree in couple and family therapy, I embraced a relational and systemic understanding

as I learned about social constructionism and the ideas of Bateson and Maturana. My perspective shifted from an individual to a relational perspective, and my interests turned toward evoking therapeutic change, and exploring the use of language in fostering such change.

I continued to practice clinically, adhering to the core social work values of service and social justice while honoring the dignity and worth of my clients, the importance of human relationships, and the significance of my own integrity and competence (National Association of Social Workers [NASW], 2017). However, the knowledge I was gaining in my doctoral program expanded both my therapeutic stance and post-modern understanding. I began to look more closely at my work with clients. It became clear that although my approach was solution-oriented, I was also employing circular questioning and curiosity. My interests were shifting as I continued to develop my approach of identifying and utilizing clients' strengths and resources to co-construct solutions. Over time, I began to incorporate new knowledge, including the concepts I learned in my study of hypnotherapy: attunement, empathic understanding, relational understanding, and the creation of change through the altering of time. I became increasingly more fascinated with recursive circular language and its role in creating therapeutic change grew, which guided me to Karl Tomm's in-depth descriptions of reflexive and circular questions. My discovery of the circular and reflexive nature of questions used in internalized other interviewing prompted me to explore Tomm's unique approach. For me, the IOI approach was groundbreaking. I started exploring its use, as well as the theory informing it. My curiosity and fascination sparked the ideas that have resulted in this dissertation.

The IOI approach resonates strongly with me as a developing clinician. I am intrigued by the fact that it evolved from Karl Tomm's commitment to social constructionism, post-modernism, bringforthism, and systemic thinking. It illustrates the exquisiteness of empathic engagement and listening, as well as Tomm's belief in the client's ability to change. In the forthcoming chapters, I do my best to illuminate the philosophical roots, historical context, inner workings, and broad application of IOI, demonstrating how this unique approach offers a way to move forward at a time when conflict and separation seem to be tearing apart individuals, families, and communities.

CHAPTER II: ETHICAL COMMITMENTS

Tell them they should always try to act so as to **increase** the number of

choices; yes, **increase** the number of choices!

—*Heinz von Foerster* (1992, p. 16)

Throughout his life, Karl Tomm was influenced by a multiplicity of elements that

contributed to his therapeutic approach and inspired his commitment to ethical practice.

The breadth of his experiences, both personal and professional, profoundly influenced his

theoretical and philosophical assumptions, leading him to move from a first- to a second-

order perspective. In addition, his collaboration with various colleagues over the years

contributed to the knowledge and experience he gained through his exposure to different

therapeutic approaches and models. This resulted in a personal commitment to maintaining

an intentional and ethical therapeutic practice. In the following pages, I will explore these

aspects of Tomm's work: his commitments to social justice and collaborative practice, his

political sensitivities, his conceptualization of the dialogic relationship, and his positioning

of the therapist as part of the family system.

Social Justice

Considering ethics "a domain of concern for the wellbeing of others" (K. Tomm,

personal communication, August 12, 2019), Tomm has explored the impact of cultural

practices and beliefs on family members' interactions. Inspired by "constructivist, social

constructivist, hermeneutic, feminist, and post-structural critiques" (Strong, et al., 2008,

p. 174), he has examined the role of discourse in communication between therapists and

clients, looking at the ways in which broader social and political practices mold what

happens in therapy and affect therapeutic outcomes (Strong et al., 2008; Tomm, 1998a).

This has become a guidepost for the way Tomm conducts therapy and interacts with clients (Strong, et al., 2008).

According to Tomm (1998a), consideration for the relevance of social justice is vital to the development of the family therapy field. As he explains it, "there is a virtual epidemic of sexism, heterosexism, racism, ethnocentrism, classism, parentism, professionalism, and so forth in our culture and communities" (p. 181). In his work as a family therapist, he has closely attended to "the psychological suffering" (Tomm, 2003, p. 30) caused by the aforementioned epidemic, resulting in profoundly deleterious effects on individuals and families that generate "an enormous amount of conflict and misery" (Tomm, 1998a, p. 181). Asserting that this distress is rooted in social injustice, Tomm (1998a) poses a call to action:

> When I . . . see how our culture is creating and replicating structures of social injustice that generate pathologizing dynamics between us and within us as human beings, I feel compelled ethically to do something about altering our cultural drift as well as doing therapy. (p. 181)

Tomm believes that his ethical responsibility to promote social justice is not a matter of whether, but rather of "'how', 'what', 'when', and 'where' [his] influence is exercised" (Tomm, 2003, p. 31). From his perspective, to see injustice and not challenge it is to conspire with it. Therefore, therapists have an ethical responsibility that goes beyond their roles as citizens, to actively promote social justice and challenge injustice. This commitment has had a significant impact on Tomm's work as a therapist, teacher, and writer, as well as on his ways of engaging within his community, culture, and society.

Tomm has reflected on the effects of some of his personal experiences and how they informed his ideas about social justice. Born to German immigrants, he self-identified as German, which caused him to be bullied during his school years. Eventually, he learned "to conceal [his] cultural heritage" (Tomm, 2014a, p. 2), which sensitized him to issues of social injustice. His mother's extended illness and eventual death from cancer when he was eight years old developed within him a "deep personal commitment to try to help those who [are] suffering" (p. 2). Tomm's (1998a) late partner, philosopher and feminist scholar Winnie Tomm, was a "major contributor to [his] own understanding of the pervasive injustices in families and cultures that are based on gendered assumptions about reality" (p. 180). Her influence helped him "open up some significant blind spots in [his] male-based reality" (p. 180), leading to a renewed sense of awareness that inspired him to address the gender-based equity within their relationship. These experiences also impacted his therapeutic work with couples ensnared by cultural stereotypes.

Tomm recognized that an enormous challenge faced by the field of family therapy is the question of "how to address larger social issues of unequal power and social injustice, and how the language, meanings and practices used by families themselves are informed by cultural processes and beliefs" (Denborough & Tomm, 2001, p. 118). What therapists do about inequities depends, in part, on whether they are operating from a first- or second-order perspective, a topic I will expand upon in greater detail in Chapter III. Briefly, a first-order perspective positions the therapist to see families "as observed systems . . . grounded in traditional systems theory and first-order cybernetics" (Tomm, 1998b, p. 409). Von Foerster (2003) describes the difference between the first- and second-order perspectives by explaining that first-order cybernetics can be thought of as

"the cybernetics of observed systems . . . while second-order cybernetics is the cybernetics of observing systems" (p. 285). First-order therapists see themselves as positioned outside the family system, observing and interacting with the system from their own perspective. Alternatively, therapists grounded in a second-order perspective assume "the theoretical position of observing systems" (Tomm, 1998b, pp. 409-410). They simultaneously observe and are influenced by their observations, as they are part of the system they are observing. From this point of view, therapists are oriented toward intervening "in the ways [they] see things and into the ways in which family members see themselves, each other, and their relationships" (p. 410). Family therapists working within a second-order perspective see themselves as an integral part of a cultural process that enables them to either contribute to power discrepancies and perpetuate injustice, or work toward the co-creation of constructive change. As Tomm (1998b) explains:

It is a matter of ethics whether the potential power of the second-order perspective is used to improve the human condition and add to a person's life, or is used for the advantage of those who are already privileged in having access to this kind of knowledge. (p. 413)

Recognizing and identifying himself as a person of privilege and power, Tomm assumes an even greater responsibility to promote social justice. He maintains an awareness that, if unnoticed and unexamined, the power he holds can lead to domination and exploitation. Attending to certain cultural assumptions, such as identifying a pattern of male privilege and dominance, can serve to utilize the therapeutic process to challenge traditional, culturally embedded stereotypes that contribute to family conflict (Tomm, 1998a). Tomm's work with clients has extended into his personal life, making him more

"aware of [his] own patterns of perpetrating social injustice and trying to address these" (Denborough & Tomm, 2001, p. 119) to the best of his ability. He characterizes himself as "a white heterosexual male who has lived many middle-class privileges" (Tomm, 2014a, p. 2), inspiring him to adopt "a proactive stance against other injustices connected to [his] privilege, like white supremacy, . . . heterosexism" (Tomm, 2003, p. 30), and sexism. The professional status he holds through his appointment at The University of Calgary afford him many privileges, whether he desires them or not, that can have "power and influence" (p. 30) over everyone with whom he interacts.

According to Denborough and Tomm (2001), one way therapists can become more aware of the ways in which they contribute to social injustice is by recognizing their "own patterns of collusion . . . [through the process of] deconstructing perpetrator-ship" (p. 120). The authors identify three levels of perpetration. Primary perpetrators "are those who themselves commit a particular injustice" (p. 120). Secondary perpetrators, either directly or indirectly, are considered to be complicit, while tertiary perpetrators "collude with the values and ways of thinking in a community that make the unfair actions possible" (p. 120), such as colluding with beliefs that are racist or homophobic. When he first began exploring these levels of perpetration, Tomm realized the degree to which he participated in social injustices. Since then, he has sought to address his collusion and actions, not only by regretting them, but also by taking responsibility for them. He believes that this has allowed his actions as a perpetrator to become "a generative source of change and restorative action" (p. 121) in his life and work.

By examining his actions and interactions with clients, Tomm discovered the significance of "distinguishing the action's intent from its effect, [which] translate[s] into

a concept of therapeutic distinctions on what influentially is listened for and conversationally 'brought forth'" (Strong et al., 2008, p. 179). Influenced by the ideas of social constructionism and bringforthism, theories I will expand upon later, Tomm recognized "different observers bringing forth different distinctions, tendencies linked to their histories and prior social interactions" (p. 179). Tomm places great importance upon the practice of "bringing forth particular distinctions as ethical and political acts of power" (p. 179). He emphasizes the need to pay attention to the political position a person implicitly chooses.

Tomm's work with families has been influenced by Maturana's theory of cognition and Gergen's social constructionist theory (Tomm, 1998b). For example, he has incorporated Maturana's idea of love—which I will elaborate upon in Chapter III— by emphasizing its role in the "process of social interaction in generating language[, which] favors the centrality of the family in the creation of knowledge among its members" (Tomm, 1998b, p. 411). This knowledge, which emerges from a second-order perspective, can be used in different ways and for different purposes. Tomm has used it to focus his attention on a key ethical issue: how knowledge is used, particularly in the practice of therapy. He explains that there are "power dynamics in the generation and maintenance of knowledge and its influence in determining social structures, including major social injustices" (Tomm, 1998b, pp. 412-413). Accordingly, this gives therapists an opportunity to see things from a more expansive perspective and be intentional about the way they approach their work.

Gosness et al. (2017) promote the idea of *opening space*, which "is about the value of expanding choice for those we work with, rather than imposing our own choices

and assumptions" (p. 24). When opening space for others, therapists commit to four specific values: "1. Living with curiosity; 2. Opening space for enlivened possibilities; 3. Inviting others to entertain change; and, 4. Proactively including others (while respecting their possible choice to remain apart)" (Gosness et al., 2017, p. 25).

As family therapists, we are privileged to witness and empathically engage with our clients' experiences of social injustice, and we are responsible for their safety and well-being. Therapists need to recognize that "many of the mental difficulties that persons in families experience arise . . . through social processes of unfairness and injustice" (Denborough & Tomm, 2001, p. 119). Accordingly, they must expand their focus to encompass "larger social processes" (p. 120), rather than limiting the scope of their attention to the individual family. Tomm's commitment to this goes beyond other approaches in therapy that assist clients in coping with certain unjust situations. He exposes the roots of beliefs that add to clients' pain and supports their efforts to challenge whatever injustices they might be facing.

Tomm explains that therapists are caught in the vice of irony, as we are compensated by and "benefit from the consequences of social injustice" (Tomm, 2003, p. 30), since we provide a service to people who are in emotional pain and bearing the consequences of such injustices. This paradox, of being both the balm and the benefactor of the effects of social injustice, holds us accountable to engage in ethical practice and promote social justice—an ideal that, according to Tomm (2003) is "an 'ethical imperative'" (p. 31). Such an imperative calls upon us "to devote at least a portion of our time to addressing these social issues" (Denborough & Tomm, 2001, p. 120), which we can do in many ways, including directly through social action, teaching, and writing.

In order to promote social justice, it is important to first determine "what exactly constitutes justice and injustice" (Tomm, 2003, p. 31). According to Tomm (2003), disagreement about this is common and "is aggravated by the inevitable limitations we have in understanding the lived experience of others" (p. 31). Identifying himself as a person of privilege who is apt to be limited in his awareness of others' lived experiences, Tomm (2003) explains:

> I need to 'hold myself suspect' with respect to what I consider just or unfair, and seek to see the effects of my privilege through the eyes of those who are less advantaged. This enables the awareness I need to become more coherent in promoting social justice. (p. 31)

Beyond his work with clients, Tomm is also committed to standing up to injustice in the community and in the larger culture. He describes feeling a sense of guilt by association over his German heritage, due to the atrocities committed by his ancestors during the Holocaust, and recognizes that a connection to "the values of anti-Semitism were part of the community in which [he] was raised" (Denborough & Tomm, 2001, p. 121). This led him to understand that if he colluded, whether "consciously or unconsciously, [he, in some way,] contribute[d] to anti-Semitism" (p. 121). Tomm found that "acknowledging the profound injustices . . . [and] expressing deep regret and remorse . . . [enabled him] to make a stronger stand against anti-Semitism in [his] everyday life[,] . . . rather than deny [his] guilt feelings" (p. 121). Like Tomm, individuals can use feelings of guilt in productive ways, in order to search "the nuances of perpetratorship" and "do something about [their] participation in these processes" (Denborough & Tomm, 2001, p. 121). Tomm's hope regarding deeper reflection and exploration of one's level of

perpetration is "to move in the direction of less violence and more respect and to contribute to patterns of interaction that promote healing and wellness" (p. 121). In a world of continued violence and human suffering, "human respect is something that needs to be continually regenerated and revitalized" (p. 121).

Dialogic Relationship

In his practice of challenging societal practices he considered unjust, Tomm focused on those taking place in the course of the therapeutic relationship. In particular, he became concerned with "issues of therapist authenticity and intentionality and about being honest" (Bubenzer et al., 1997, p. 96), identifying the difficulties that arise due to the diverse agendas we have as therapists.

In his therapeutic practice, Tomm uses questions to help "bring forth preexisting knowledge in clients [to] . . . make it possible for individuals to apply this knowledge in new ways that would be useful for them" (Bubenzer et al., 1997, p. 90). He uses various types of questions to elicit this, including one that juxtaposes two choices with one another. Known as a *bifurcation question*, it invites the client to make a choice in order "to mobilize and align a person's emotional response" (Tomm, 1993, p. 67). The goal is to support clients' personal agency by giving them the freedom of choice. Reflexive questioning, another style that Tomm employs, "is intended to orient people to become more aware of their existing knowledge" (p. 90). Asking these types of questions supports the commitment to work ethically, because—as explained by von Foerster (in Bubenzer et al., 1973)—"to be ethical[,] one should always act so as to open increased choice" (p. 91).

When acting to open space for their clients, therapists must consider the possibility that they can do harm. Tomm contends that as therapists, we must prioritize our clients' needs over our own. For example, if social justice is important for the therapist but not part of the client's stated concern, then bringing this forth is the therapist's need. If our needs as therapists clash with our clients' needs . . . we cross the line to become unethical, into imposing our ideas [and] values upon the other" (K. Tomm, personal communication, August 13, 2019). It is "reasonable for us to invite [clients] to reflect upon our views, and see what we see with respect to the advantages of those views, and invite them to entertain that" (personal communication, August 13, 2019). However, he cautions against imposing our needs or ideas upon clients, as this he considers an act of violence, which he defines as "any imposition of one's will upon another, regardless of whether one is doing so physically, ideologically, chemically, or socially" (personal communication, August 13, 2019).

Tomm considers all client-therapist interactions to be potentially interventive (Tomm, 1987a, 1987b, 1988), which beckons us to attend to the ethical implications of our practices. As a way to ameliorate the apprehension and concern therapists feel about doing no harm, Tomm created a framework of *ethical postures* (Strong et al., 2008)—which I will expand upon later in this chapter—designed to increase our awareness of the influence we have over our clients, and to guide us as we move through our therapeutic conversations.

Therapist as Part of the System

Tomm describes the development of the field of family therapy as a sequence of three somewhat overlapping phases. In the first phase, individuals are no longer seen as

separate individuals; they are now considered to be parts of the family system. Although seen as mechanistic systems in which family members' reactions serve to maintain patterns through certain dynamics and homeostasis, Tomm views cybernetics as providing some basic concepts for family therapy (Bubenzer et al., 1997; Tomm, 1988a). According to Tomm, foundational ideas such as circularity, patterns, circuits, and feedback loops are vital for understanding human relationships (Bateson, 1972; Bubenzer et al., 1997).

First-order and second-order change, ideas developed by the MRI group (Watzlawick, Weakland, & Fisch, 1974), are different from first- and second-order approaches. First-order change is that which occurs within the same context, such as "a change from one behavior to another within a given way of behaving" (Watzlawick et al., p. 44). Second-order change, or "change of change" (p. 25), occurs "within [a] new frame of reference" (Collins & Tomm, p. 108). An example would be a therapist reframing a behavior to:

> change the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the "facts" of the same concrete situation equally well or even better . . . thereby chang[ing] its entire meaning. (Watzlawick et al., p. 120)

First- and second-order perspectives and approaches denote differences in the relationship between the therapist and family within the therapeutic system (Bateson, 1972; Hoffman, 1985; von Foerster, 1992). The first-order perspective, with its grounding in systems theory and first-order cybernetics—what Tomm refers to as "systems analysis" (K. Tomm, personal communication, August 12, 2019)—positions the

therapist as an outside observer of the observed system, who interacts with the system according to their determination (Tomm, 1998a). Tomm (1998a) asserts that viewing families from this perspective, as systems regulated by certain dynamics that maintain behavioral patterns, has some negative consequences, including "trivializ[ing] both persons and families and . . . justify[ing] the authority of professionals to act on them unilaterally" (p. 182).

Most importantly, Tomm identifies that second-order cybernetics informed the second phase of development for the field of family therapy, by proposing a "cybernetics of cybernetics" (K. Tomm, personal communication, August 12, 2019)—a description attributed to "Heinz von Foerster (1973) . . . who suggested the phrase . . . to Margaret Mead" (Bubenzer et al., 1997, p. 88). Also referred to as "systemic understanding" (K. Tomm, personal communication, August 12, 2019), second-order cybernetics presents a new way of conceptualizing family systems, wherein "we as observers see ourselves in circular interaction with what we see while looking for the circularity out there" (Bubenzer et al., p. 88). The shift, according to von Foerster (1992), offers a "turn from looking at things out there to looking at looking itself" (p. 11). Tomm expands upon this description by explaining it as a turn from "looking at one's looking to see what one is seeing, and seeing how seeing in a particular way influences one's position in the system, listening to one's listening, assuming one is always assuming, and knowing about one's knowing" (personal communication, August 12, 2019). He recognizes second-order cybernetics as a way to understand how we reflect on our interactions, how we make observations, and how we generate meanings through the process of "co-constructing

ideas, beliefs, and realities . . . [that promote] behavioural change as secondary to

changes in understanding" (Denborough & Tomm, 2001, p. 118).

This second-order perspective, grounded in "Maturana's bringforthism, Gergen's

social constructionism and von Forester's second-order cybernetics" (Tomm, 1998b, p.

410), alters the therapist's position. By both observing and being influenced by what they

are observing, the therapist becomes part of the system within which they are situated.

Patterns of interaction are generated and maintained largely by how family members

perceive and conceptualize what they see. As both an observer and part of the therapeutic

observation, the therapist needs to look closely at how they look, at the patterns inherent

in the looking, at how the different ways of doing so affect their own behavior, and at the

effect all of this has on their interactional patterns with family members. Such a

perspective can be seen in various models of therapeutic practice, such as Milan systemic

therapy, collaborative language systems therapy, solution-focused therapy, and narrative

therapy.

Throughout his career, Tomm (1998b) has been cautious about and mindful of

how therapists use their knowledge of social interaction "in the construction of

therapeutic realities" (p. 412). Due to the ways in which it generates and maintains

knowledge, a second-order perspective reveals the power dynamics that establish social

structures, both just and unjust. As therapists, we can use such ways of seeing to

influence clients toward preferred patterns of interaction, while remaining cognizant of

the fact that we can also use "the theory of social constructionism to impose and exploit"

(p. 413).

The perspective, which affects how therapists are positioned in the therapeutic process, as well as how they conceptualize therapeutic change, also has an effect on who needs to be present in the therapy room. Since the first-order perspective orients therapists to directly intervene in order to create change within family interactions, multiple family members need to be present in the room, such as in Minuchin's structural family therapy (Tomm, 1998b), for example. However, second-order therapists are interested in the way they see what they see, as well as in how family members view themselves, others, and the relationships between them. Accordingly, second-order therapeutic change is seen as a secondary result that follows other changes occurring within "patterns of seeing and giving meanings" (Tomm, 1998b, p. 410). Although it may be preferable to incorporate multiple family members in therapy, it is not critical from the second-order perspective, as the family members themselves can greatly influence the process of generating and maintaining meanings.

First and second-order approaches are grounded in different epistemologies, with "first order approaches grounded in empiricism, [and] . . . second-order approach[es, such as the one developed by] the Milan team[,] . . . grounded in constructivism" (Collins & Tomm, 2009, pp. 109-110). According to Tomm, one must be freed up from being bound by empiricism and the world of objectivity, "and instead entertain alternative ways of thinking, believing, and seeing the world" (p. 110).

Political Sensitivities

Consistent with the shifting field of family therapy, Tomm (1998a) has focused his attention on "the politics involved in the social construction of the realities that organize people's lives" (p. 179). When we view our clients through the lens of social

constructionism, we consider the viability "of constructing alternative meanings for any experience" (p. 179), knowing that the consequences will change depending on which meaning is prioritized. Tomm poses the questions, "Which construal or 'reality' gets selected to be acted upon? Who decides which construct . . . is to be privileged?" (p. 180). Consideration of these questions leads to several others: What will be the short- and long-term effects of choosing one construct over another? Who will most likely be advantaged? Disadvantaged? Which stakeholder in the system will privilege one construct over another, or do all voices carry the same weight? How aware are we of the power we hold as therapists to privilege our preferred constructs? These questions and many others can provoke us to wonder about how we can be fair and ethical in our process of constructing meaning in our clinical work.

Tomm (1998a) first began exploring these politics "in the domain of gender" (p. 180), at a time when feminist family therapists started bringing attention to the systematic privileging of male constructions, drawing attention to "how this usually disadvantaged females" (p. 180). Tomm recognized that the emerging "politics of the social construction of reality" (p. 180) were strongly manifested in racism and ethnocentrism. Through work he was involved in with therapy groups in New Zealand and New Orleans, he started "to see the pervasiveness of White European domination of other cultures through overt and covert colonization" (p. 180). The values of White Europeans, "socially constructed as superior to anything else[,] . . . served to justify all kinds of exploitation and oppression" (pp. 180-181). His work with these therapy teams involved inviting a dominant group to hear the experiences of the disadvantaged group. It was a process of privileging the marginalized voices, then collectively working to "rectify the imbalance of power" (p.

181) by holding the privileged group accountable to the one that was disadvantaged and marginalized.

Tomm (1998a) conceptualized a third phase in the evolution of family therapy, one that involved "looking at and listening to the cultural, community, and family politics of looking and listening, including our own looking and listening" (p. 183). Beyond simply looking at the ways family members organize their behaviors by looking at one another, the third phase entails attending to "the real political effects of certain patterns of seeing that orient and influence our patterns of behavior" (p. 183). Although social constructionism provided a theoretical basis for the creation of alternative realities, Tomm did not believe it provided adequate support for this third phase, because within this construct of alternative realities, one possible reality cannot be chosen and acted upon over another. Tomm could not find an explanation for how the social systems constructing the numerous realities came to be known to begin with, deeming social constructionism "groundless . . . [, which] limits its acceptability for . . . those who are looking for a basis for making choices among various realities" (p. 183). For this third phase of family therapy, Tomm believed there must be a theory that could serve as a framework for making "ethical choices among alternative realities" (p. 183) and guide us toward some.

Tomm emphasizes that a therapist can take an ethical posture in the drawing of distinctions about a client, considering "how those distinctions influence [and organize the therapist]" (Bubenzer et al., 1997, p. 89). An example of this is making the distinction of a client as resistant. The way this distinction is organized will have an effect on the therapist's orientation and subsequent choice of intervention. Identifying closely with de

Shazer's (1984) ideas about resistance, Tomm believes that making such a distinction will create a change in the therapist's orientation and ethical posture, explaining that "as soon as you make it, [it] influences you and your relationship" (Bubenzer et al., 1997, p. 89). Therefore, being able to "distinguish the distinction (second-order cybernetics)" (p. 89) will expand the therapist's ability to envision its potential impact.

While therapists aim to understand their clients' lived experience, their ability to do so is limited. This adds to the difficulty in determining what defines justice and injustice. Tomm (2003) addresses this difficulty and emphasizes the importance of therapists remembering that those in positions of privilege generally lack awareness of the true experiences of those who suffer social injustice. He asserts that it is helpful to focus on moving toward "change that might be mutually acceptable for the moment" (p. 31), rather than attempting to reach an agreement regarding what is fair. As a self-identified person of privilege, Tomm feels compelled "to 'hold [him]self suspect'" (p. 31) regarding what he believes is or is not just. Accordingly, he regularly aims "to see the effects of [his] privilege through the eyes of those who are less advantaged" (p. 31). In so doing, he is able to open himself up to being more politically sensitive and aware of the ways he can promote social justice.

Collaborative Practices

Tomm's collaborative approach to therapy is "shaped by structural and poststructural approaches to systemic practice" (Strong et al., 2008, p. 183), which reflect how problems are understood in the context of relational interaction patterns. Whereas the structuralists saw patterns "as objectively assessable" (p. 183), the poststructuralists asked questions about this objectivity, "seeing 'structures' as cultural ways to put

language to phenomena" (p. 183). Concerns arose regarding the ethics of therapists attempting to understand their clients' experiences within the context of their own worldview. As a result, social constructionist approaches were introduced with the intention of emphasizing and eliciting co-construction. These approaches include the use of reflexive participation, curiosity, and collaboration, which invite "clients' resourceful ways of talking that draw on their preferences and resourcefulness" (p. 183).

Tomm has spoken about attending to the ways in which therapists communicate with their clients, as well as the ways in which clients' responses can affect therapists' mindful practice. Tomm demonstrates this through his use of attunement and resourcefulness in his dialogue with clients. This practice of attuning to the client is something Tomm demonstrates "in an interventive or reflexive way" (Strong et al., 2008, p. 183) through his verbal and non-verbal communication.

Development of Ethical Postures

Tomm's commitment and responsibility to ethical practice can be understood conceptually via the ethical postures he developed, which "operationalize[d] his social justice concerns" (Strong et al., 2008, p. 180). He demonstrated these postures in his attunement to the relationship between the client and therapist in dialogue, his understanding of himself as part of the system, his commitment to remaining politically sensitive, and his collaborative work with families. Like Tomm, when therapists view therapeutic dialogue through a social constructionist lens, we can see "how understandings of experiences are negotiated and constructed between people" (Strong et al., p. 180). By recognizing that "there is no objective experience . . . and all experience is subjective" (Bateson, 2002, p. 28), we are better able to understand clients' subjective

realities and construct what it is they prefer. This understanding guided Tomm's efforts to create ethical postures that would help therapists become more intentional when collaborating with clients.

In designing the ethical postures, Tomm borrowed ideas from positioning theory, which asserts that "collaborative relationships can be intentionally forged by speakers, since their positions with respect to each other and to the conversation's direction are worked out on a turn-by-turn basis" (Strong et al., 2008, p. 180). Depending on the cultural discourse or dominant narrative, "individuals can position themselves, or be positioned by others" (p. 180). Tomm developed his framework of ethical postures to inspire therapists "to be (a) mindful when positioning themselves in moment-to-moment relating with clients, (b) intentional in selecting postures, and (c) reflexively aware of how their postures are being taken up (or not) by clients" (p. 181).

Posture, as defined by Tomm (1987a), is "an enduring constellation of cognitive operations that maintain a stable point of reference which supports a particular pattern of thoughts and actions and implicitly inhibits or precludes others" (p. 5). The framework consists of four possible postures with four quadrants that contain therapists' intentions and cognitions (see Figure 1). The vertical axis represents a continuum from closing space or reducing options on the top—a pathology-based approach, to opening space or increasing options on the bottom (a wellness-based approach). The horizontal axis is set up as a continuum from secret knowledge and hierarchical relationship on the left, where the "locus of intended change is non-conscious," to shared knowledge and a collaborative relationship on the right, where the "locus of intended change is conscious" (K. Tomm, personal communication, August 12, 2019). The four postures in each of the four

quadrants, beginning in the upper left quadrant and moving clockwise, are manipulation,

confrontation, succorance, and empowerment.

Figure 1
Karl Tomm's Framework of Ethical Postures Portrayed by Two Continua (Axes)
(Tomm, 2019, slide 8)

Reducing options
or closing space

MANIPULATION   **CONFRONTATION**

Locus of change   Locus of change
is nonconscious   is conscious

SUCCORANCE   **EMPOWERMENT**

Increasing options
or opening space
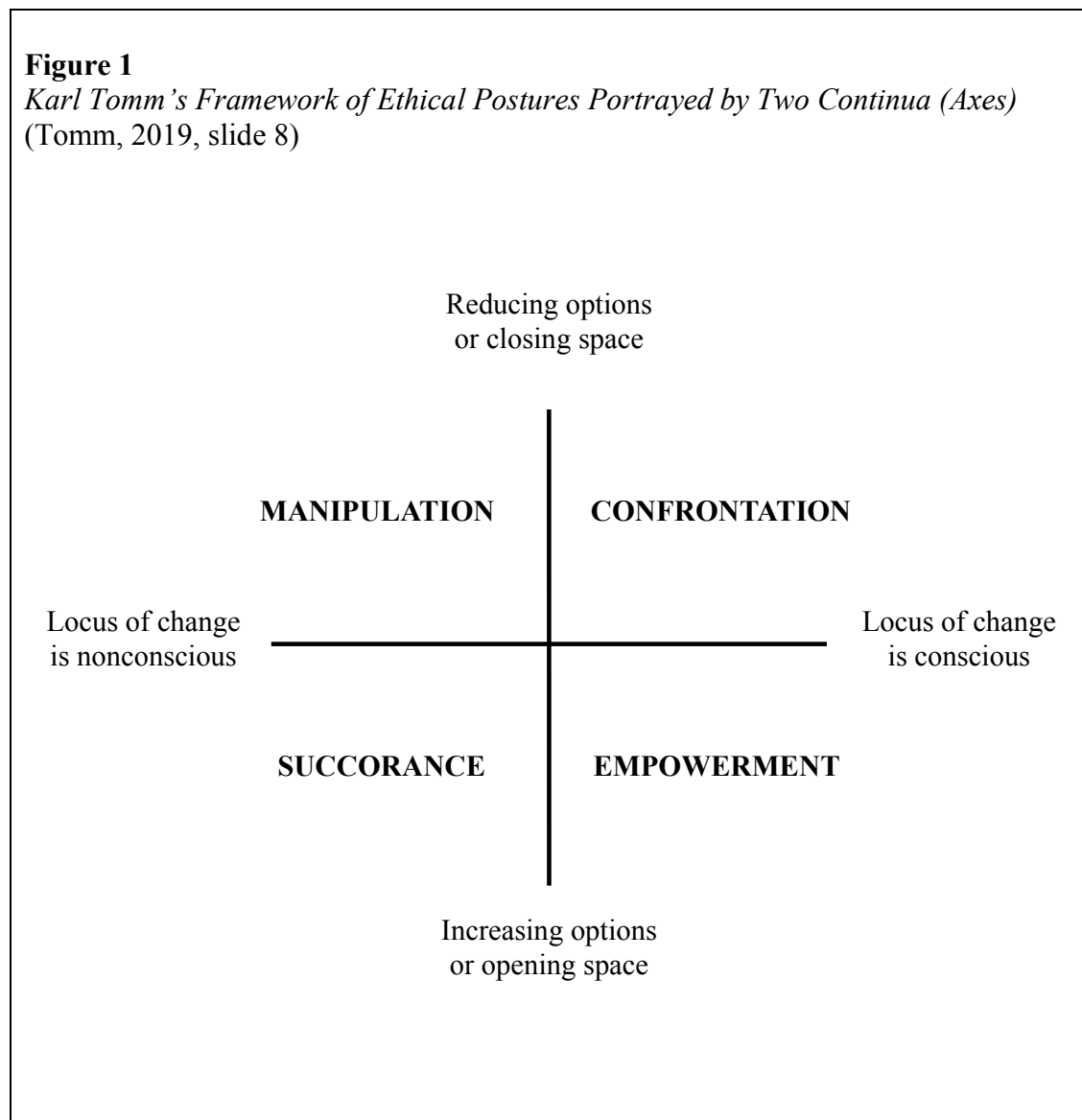
The posture of manipulation is one of "professional knowledge [that] reduces

client options" (Strong et al., 2008, p. 181). Therapists assuming this posture foster

change outside of the client's conscious awareness, such "as when using counsellor-

directed hypnosis to help an addicted client quit smoking" (p. 182). In the posture of

confrontation, which is characterized by "shared knowledge [that] reduces client options"

(p. 181), change is elicited "on a more client-conscious level, using interventions to reduce client options, such as by translating irrational cognitions" (p. 182).

Using a term "picked up from Bateson" (K. Tomm, personal communication, August 12, 2019), Tomm defines the posture of succorance as one in which the therapist's "professional knowledge increases client options" (Strong et al., 2008, pp. 181-182). In this posture, the professional contains special knowledge that is separate from that of the client. The locus of intended change is not conscious, and the posture can be used "to open space and increase options for clients' healing and wellness" (p. 182). This posture has been likened to the parenting of children.

The fourth posture, empowerment, situated in the bottom right quadrant of the framework, serves to increase client options. This posture, in which the locus of intended change is conscious, involves a collaborative exchange of knowledge between the therapist and the client. Therapists assuming this posture invite clients "to take up increased options while opening conversational space for [them] to discuss their ideas on wellness" (Strong et al., 2008, p. 182). Although Tomm privileges the empowerment posture, he asserts that any of the four can be ethical if therapists use them to intentionally attend to their clients' needs and improve their well-being. He explains, "We, as therapists, need to assume responsibility for every choice we make" (K. Tomm, personal communication, August 12, 2019).

Tomm points out that his own personal history parallels the framework of ethical postures. He began with manipulation, then moved toward confrontation during his time at McMaster University (K. Tomm, personal communication, August 12, 2019). Later,

during his work with the Milan team, he assumed the posture of succorance; and finally,

through his work with Michael White, he came to assume the posture of empowerment

CHAPTER III: PHILOSOPHICAL DEVELOPMENTS AND THEORETICAL INSPIRATIONS

The *pattern which connects is a meta-pattern*. It is a pattern of patterns. . . . Indeed, *it is patterns which connect.*

—*Gregory Bateson* (2002, p. 10)

This chapter presents an overview of the main philosophical and theoretical influences that have inspired and informed Karl Tomm, guiding and shaping all aspects of his work, as he and the field of family therapy have mutually evolved. The discussion covers ideas from general systems theory, Bateson's cybernetics, communication theory, social constructionism, and Maturana's bringforthism.

From Lineality to Circularity

Epistemology is "central in the process of a therapist *coming to know*" (Tomm, 1986, p. 375). According to Tomm (1986), "how and what a therapist comes to know and 'believe' about a family . . . [is] a crucial element of the therapeutic process" (p. 375). Tomm's epistemology first began to develop during his medical training. A number of professional experiences affected him significantly and inspired him to gravitate toward family therapy and the exploration of interactional patterns in relationships (Collins & Tomm, 2009; Strong et al., 2008; K. Tomm, personal communication, August 12, 2019). During the first year of his medical internship, Tomm worked hard to preserve the life of a terminal cancer patient who had attempted suicide. He struggled with the idea that while he was working hard to keep this patient alive, the client himself wanted to die. This experience contributed to Tomm's belief that "he had a 'blind spot'" (Strong et al.,

2008, p. 175) and was missing something critical. It led him to change his focus from internal medicine to psychiatry.

During the first year of his psychiatry residency, Tomm puzzled over why a 14-year-old female patient continuously ran away from home when she seemed to have such a caring and devoted family (Collins & Tomm, 2009). An experience Tomm considered pivotal for creating a shift in his epistemological stance occurred while he was working with a couple at McMaster University in Ontario, Canada. Tomm noticed a change in the couple's pattern of interaction when the wife, who had once received support from her husband while she was suffering from a "deep depression," became the source of support for her husband following his involvement in a car accident that resulted in a charge of manslaughter and bout of depression. Tomm noted that in her husband's time of need, the wife rose to the occasion to help him. However, once the charges against him were dropped and his mood subsequently improved, her mood deteriorated once again. When her husband resumed his previous caretaking role, she again entered into a depression and later died by suicide. This case, which will be further discussed in this chapter, inspired Tomm to look at patterns of interaction and attend to the way he was seeing his clients.

Prior to a change in the field of family therapy during the late 1970s and early 1980s, which involved a shift from a first-order to a second-order perspective (Denborough & Tomm, 2001; Hoffman, 1985; von Foerster, 1992, 2003), clients were largely viewed from a "systemic-cybernetic perspective" (Strong et al., 2008, p. 175), and families were considered homeostatic "information-processing systems" (p. 176) that demonstrated patterns of communication. During this time, Tomm drew from "von Bertalanffy's ideas about systems, notions of feedback loops and homeostasis" (Collins

& Tomm, 2009, p. 106), in addition to other systems theory ideas, to expand his understanding of families.

von Bertalanffy (1975) explains that "in order to understand an organized whole we must know both the parts and the relations between them (p. 153). He defines a system as "a set of elements standing in inter-relation among themselves and with the environment" (p. 159) that can be broadly defined by "the interactions of the component elements" (von Bertalanffy, 1972, p. 37). Describing systems as composites made up of component parts, Tomm explains that "a change in any one part will affect every other part" (K. Tomm, personal communication, August 13, 2019). Using the metaphor of a mobile (von Bertalanffy, 1972, 1975), he goes on to explain that "if you move something in a mobile, everything else adjusts in relation to that movement" (K. Tomm, personal communication, August 13, 2019). Thus, a change in one family member will elicit change in other family members. "so that the system adjusts itself in relation to the change in one individual" (personal communication, August 13, 2019).

When first learning systems theory, Tomm (1998a) was perplexed about the specific meaning of the "systems theory truism that 'the whole is more than the sum of the parts'" (p. 176). What became clear to him was that the parts themselves had unique relationships with each other that contribute to the totality, therefore making the whole greater than the sum of its parts. He recalls, "I needed to realize that if I wanted to be a systemic therapist, I needed to find a way to privilege those relationships" (K. Tomm, personal communication, August 13, 2019). For Tomm (2014a), this insight "clarified the core of systems thinking" (p. 14). Both he and the field of family therapy were shifting from linear to circular thinking, from what happens *within* to what happens *between*

individuals. As Von Foerster (1992) asserts, "cybernetics is many different things to many different people, but . . . all of those perspectives arise from one central theme, and that is that of circularity" (p. 10). The key is the centrality of relationships. This shift in perspective influenced Tomm to develop a way of interviewing whole families and determining that certain skills in family therapy are useful for training new therapists.

After beginning the Family Therapy Program in Calgary in 1972, Tomm began to work on developing a blended approach to working with families. He explored other models and visited other family therapy programs, learning and integrating their ideas into the family therapy model he developed in Calgary. From Minuchin, he incorporated "concepts about boundaries and subsystems" (Collins & Tomm, 2009, p. 107). While at the MRI in Palo Alto, he developed an awareness "of Bateson's work in cybernetics and the importance of positive . . . and negative feedback loops in family systems" (p. 108). From his time at McMaster University in 1968, where his work was based on psychodynamic and psychoanalytic theories and "influenced by Nathan Ackerman" (Tomm, 1982, p. 70), he learned to attend "to the emotional dynamics within family members" (Collins & Tomm, p. 108). This confluence of ideas, among others, would later be incorporated into a method he developed for his work with families, known as circular pattern diagramming (CPD). Using this approach, Tomm attempted to "integrate psychodynamic . . . , cognitive . . . , and behavioral ideas, by connecting them through a cybernetic feedback loop" (p. 107).

Tomm's newly developed model placed the greatest emphasis on cybernetic principles, specifically those considered regulatory mechanisms that underlie the identification of "circular patterns that maintain problematic behavior" (Tomm, 1982, p.

71). With a basis in general systems theory, the model also incorporated concepts derived from "cybernetics, communications theory, ethology, psychodynamics, and learning theory" (p. 72), in which the whole family was considered to be the systemic unit and target of intervention. Conceptualizing a "framework of *open hierarchical systems*" (p. 72), this approach allowed the observer to see "each element . . . at a particular level[,] represent[ing] both a holistic system at that level and part of a larger system at the next higher level . . . [, and included] . . . many biological, psychological, and social concepts in the overall model" (pp. 72-73). The original assessment sought to define and describe problems as residing at specific or multiple levels, including within the individual, the couple relationship, the parent-child relationship, the sibling subsystem, the whole family system, and the family-community supra-system (Tomm, 1982). As a way to "concretize the . . . cybernetic concept of feedback as . . . applied to family systems" (Tomm, 1982, p. 78), Tomm developed the circular pattern diagram (CPD) to "capture a core pattern" (p. 79) observed within the family system.

Tomm (1982) designed the CPD to "facilitate the shift from linear to circular thinking . . . [so that] specific behaviors are recontextualized and take on different meaning" (p. 84). It also serves to assist therapists in maintaining neutrality. As Tomm explains, when problems are seen as "circular, the issue of initiator . . . becomes irrelevant. A circle by definition has no beginning or end . . . [, thus,] as family members transcend their individual linear conceptualizations, a flash of insight may occur" (p. 85) that can lead to change. Another advantage of using CPDs is that it can be combined with other therapeutic techniques, as it permits multiple points of therapeutic intervention, depending upon the user's orientation. The diagram can also be used as a template for the

therapist or family to "construct a virtuous pattern to replace the vicious one" (p. 88). It can become a basis for developing skills and competencies in solving problems, allowing clients to be less reliant on the therapist.

Tomm continued to shift his focus "from individual problems toward relationship problems or patterns of interaction that were problematic" (Collins & Tomm, 2009, p. 108), which allowed him to understand the problem demonstrated by the couple he worked with in which the wife died by suicide. He came to recognize "the [reciprocal] organization of their relationship" (Collins & Tomm, p. 108) and "the pervasive power of such problematic patterns in family systems" (p. 107), as well as the substantial impact of interpersonal patterns on mental health. Tomm came to understand that the couple was "caught in a relationship pattern of 'over-adequate/under-adequate reciprocity'" (Tomm, 2014a, p. 5). Although the wife had complied with psychotropic medications and therapy, what resonated the most about this case was "how the power in the systemic dynamics of a couple's relationship could over-ride" (p. 5) any interventions. In the aftermath, Tomm "resolved in [himself] to avoid becoming the kind of psychiatrist who might overlook these kinds of relationship influences on the well-being of [his] patients" (p. 5). This further solidified his commitment to see "families as relational systems and to work with individual patients within their relationship contexts" (p. 5). Tomm's focus on the resolution of problems would dramatically change through his collaboration with the Milan team, which he initiated in 1978.

The Milan team emphasized that certain principles are critical to engaging in a systemic interview. In addition to the principles of hypothesizing and neutrality, they emphasized circularity, which they considered "a bridge connecting hypothesizing and

neutrality by means of the therapist's activity" (Tomm, 1985, p. 33). Bateson (2002),

noting how "the organization of living things depends upon circular[ity]" (p. 96),

described the notion of "cybernetic feedback as a core aspect of mental process" (Tomm,

1985 p. 33), which "requires circular . . . chains of determination" (Bateson, 2002, p. 96).

What first drew Tomm (1985) to the Milan approach was its innovative integration of

Bateson's concepts of circularity and cybernetic feedback. Through his collaboration

with the Milan team, he recognized that these foundational ideas were "the distinctive

feature" (Tomm, 1985, p. 33) of the interview within the five-part session. As Tomm

(1985) continued to expand his ideas about the use of language and the effects of

thaerapists' questions, he noted the difference between the Milan team's use of circular

questions, which refers to "the linguistic form and the clinical focus of the[se] questions"

(p. 34), and the process of circular questioning.

According to Tomm (1985), therapists can conceive "of the nature of mental

systems" in two very different ways, with different "units of analysis" (p. 38) and

different methods of interaction between parts of the system. The general systems theory

orientation espoused by von Bertalanffy identifies "systems of mass and energy" (p. 38).

Bateson's orientation, by contrast, is toward "identifying *systems of difference and*

pattern" (Tomm, 1985, p. 38). Von Bertalanffy primarily investigated "intact physical

organisms" (p. 38), which can serve as a basis to understand and explain those

phenomena that are physical in nature. Bateson's focus on "cybernetic circuits of

information" (p. 38) can best be used to understand mental systems for those phenomena

that are behavioral. Bateson (2002) offers a definition of mind as "an aggregate of

interacting parts or components . . . [in which] mental process is always a sequence of

interactions *between* parts. The explanation of mental phenomena must always reside in the organization and interaction of multiple parts" (p. 86).

The "theory of mind . . . is holistic . . . and is premised upon the differentiation and interaction of parts (Bateson, 2002, p. 87). Tomm (1985) understood Bateson's conceptualization of mental systems as "activated by 'differences' which do not consist of energy and have no mass . . . [, whereby] mind [can be understood as] a disembodied system of 'bits' of information 'flowing' in circuits of difference" (p. 38). In this realm, "perception operates only upon difference[, in that] all receipt of information is necessarily the receipt of news of difference" (Bateson, 2002, p. 27). What is perceived as "information consists of differences that make a difference" (Bateson, 2002, p. 92). Tomm recognized the importance of this idea as it relates to therapists' process of asking therapeutic questions. He understood that "a difference always defines a relationship between whatever categories, phenomena or entities are being distinguished[;] this relationship, in turn, is always reciprocal and hence is always circular" (Tomm, 1985, p. 38).

Bateson's ideas continued to inform Tomm as he developed his circular interviewing process. He paid particular attention to the notion of context, which is "linked to . . . 'meaning'[, such that] without context, words and actions have no meaning at all. This is true . . . of all communication . . . , of all mental process, of all mind" (Bateson, 2002, p. 14). Tomm (1985) emphasized that therapists need to determine what information is key, in order to determine "difference[s] that makes a difference" (Bateson, 2002, p. 212). By doing so, therapists are able to attend to "the domain of *context* [which] enables us to grapple with the notion of 'meaning'" (Tomm, 1985, p. 39).

Therapists must pay attention to multiple contextual levels, as "the relationship between any two levels is always circular [and] reflexive" (p. 39). Circular questions can focus on differences within and between categories—such as between people, relationships, beliefs, or actions—or on temporal differences—such as relationships between different time frames (Tomm, 1985).

The notion of circularity, quickly becoming a critical centerpiece of systemic work, attracted many clinicians during this period of time. It refocused "the purpose of a systemic interview . . . not so much [on] the lineal 'removal' of a problem, but [on] the 'discovery' of its systemic connectedness and hence its temporal 'necessity'" (Tomm, 1985, p. 44). Such an orientation essentially frees the therapist and family to generate new behavioral patterns that are free of the problem. Additionally, by including the therapist as part of the system, it enables the therapist to select "what issues he [or she] will attend to and what patterns and relationships will be explored[, allowing] the 'realities' that emerge [to be] 'relative' to the process of therapeutic interaction, not 'objective'" (p. 45). The therapist, as part of the system, assumes greater personal responsibility for his or her own actions and, at the same time, permits "family members more autonomy for theirs" (p. 45).

Starting in 1972, Tomm (1998a) developed an interest in Bateson's work about "the reciprocal nature of relationships" (p. 176), which assisted him in understanding family members' interactions through Bateson's description of cybernetic feedback loops. His CPD approach showed how clients' behaviors maintain problem patterns and focused on how pathologizing interpersonal patterns (PIPs) affect clients' experiences and mental health (Strong et al., 2008; Tomm, 1998a). Another significant contribution to

Tomm's understanding was Bateson's ideas about the circular nature of systems. As Bateson (2002) explains, "Because the system is circular, effects of events at any point in the circuit can be carried all around to produce changes at that point of origin" (p. 97).

Bateson's work helped Tomm (1998a) shift from observing individuals to observing family systems. However, at the time, he "remained an empirical observer, . . . continu[ing] to locate [him]self outside the system" (p. 176). It was Tomm's involvement and collaboration with the Milan team in the late 1970s that fostered his next important change, "from an empiricist stance to a constructivist stance" (Bubenzer et al., 1997, p. 86). Even before this, Tomm came to realize that his use of CPD with the couple in which the wife later died by suicide contributed to the couple's blaming of each other. Tomm felt that he had added "constraint to a system that was already highly constrained" (Bubenzer et al., 1997, p. 86) by demonstrating to the couple their pattern of pathology.

For this and a variety of other reasons, Tomm "abandoned [his use of] CPD . . . with its implicit grounding in objectivist assumptions" (Couture & Tomm, 2014, p. 60). He recognized the inherent constrictions of a view that maintains one reality, as it decreases the opportunity for other change-supporting realities to arise. Additionally, the CPD model reduced Tomm's ability to look at the interpersonal space, thereby maintaining the spotlight on his (and others') "persistent non-conscious drift toward individualistic thinking" (p. 60). Moving away from seeing patterns through the use of CPD allowed him to direct his attention toward how two or more people invite one another and react accordingly to each other, in a process that Maturana referred to as *structural coupling* (Maturana, 2002). This enabled Tomm to relinquish his view of

people as distinct, skin-bound individuals (Bateson, 1972, p. 460) and start looking instead at *the pattern that connects* (Bateson, 2002).

Tomm's experience with the wife who died by suicide, along with his recognition of "the isomorphism" (Bubenzer et al., 1997, p. 86) of his intervention, led him to move toward the Milan group's perspective. In addition to their method of circular questions, Tomm was also fascinated by their practice of positive connotation, a means of redefining the presenting problem that will be further explored in Chapter IV. The social constructionist view of the Milan team influenced Tomm to alter his way of understanding reality and truth, providing him with a context for understanding that aimed to free people from constraint. As he explains it, the submersion into the Milan approach was his "first explicit experience of applied social constructionism" (Tomm, 1998a, p. 178).

Through the process of shifting his orientation, Tomm (1998a) took interest in "Vern Cronen and Barnett Pearce's communications theory (1980) and Ernst von Glaserfeld's radical constructivism (1984)" (p. 177). He wanted to know "what family members saw and believed and how [these patterns] influenced their interaction with each other" (p. 177). What he witnessed and believed, and how that influenced his interaction with the family, was also of great interest, as all were considered part of the system. Tomm referred to this major transformation in his thinking patterns as a "shift to a second order perspective, to look at my looking to see what I was seeing and to listen to my listening to hear what I was hearing" (p. 177). Tomm began to adopt the "second-order perspective in family therapy" (p. 177), seeing the therapist as a part of the system who must "examine his or her patterns of looking and must work to understand how

looking and seeing things in different ways has different effects on his or her behavior and patterns of interaction with family members" (Tomm, as cited in Strong, et al., 2008 p. 410). The recognition that his way of seeing could reinforce pathology challenged him to search for ways of seeing that could support healing and wellness.

<div align="center">**Communication Theory and Reflexivity**</div>

Tomm sought to clarify "the nature of radical change—change in the basic structure of a social unit" (Cronen, Pearce, & Tomm, 1985 p. 203). For this, he turned to the coordinated management of meaning (CMM) theory, which "purports to describe a nondeterministic dialectic at the microsocial level" (Cronen et al., 1985, p. 205). The theory defines communication as a "complex interactive process in which meanings are generated, maintained, and/or changed through the recursive interaction among human beings" (Tomm, 1987b, p. 169).

Characterizing communication as circular and interactive, the theory notes that individuals "cocreate, manage, and transform the social reality" (Cronen et al., 1985, p. 205) of which they are a part. It distinguishes between structure and action to clarify how this reflexive relationship is enacted. Structure encompasses the way in which both meaning and patterns of behavior are organized; action "refers to conjointly produced sequences of behaviors" (p. 205). Structure arises from patterned and coordinated actions, which fold back onto the patterns that direct them, continuously maintaining tension and constantly emerging. Structure has no endpoint; it is continually moving and yet reliant upon the conjointly produced sequence of behavior; hence, "no isomorphism of meaning and action is possible" (p. 205). Structure, encompassing both meaning and action, is both social and particular in nature. Arising from social action, a structure's

content and organization can be pliable, organized in a hierarchical fashion, "such that one level is a context for interpreting another" (p. 205).

The CMM theory uses rules to explain how individuals' social realities are structured, guiding them as they communicate in real time. As parts of structures, rules are pliable and can be either maintained or changed with action (Cronen et al., 1985). Some rules refer to how the hierarchical structure of embedded contexts is integrated. Those having to do with "attributing meaning to a particular behavior, statement, event, [or] interpersonal relationship" (Tomm, 1987b, p. 169) are *constitutive rules*. *Regulative rules* guide actions by connecting two or more people's actions, creating a "pattern of sequential actions" (Cronen et al., p. 207) that "determine the degree to which specific behaviors ought to be enacted or avoided" (Tomm, 1987b, p. 169).

According to Tomm (1987b), "reflexivity is regarded as an inherent feature of the relationships among meanings within the belief systems that guide communicative actions" (p. 169). Reflexive questioning, which is organized by constitutive rules, also builds on Bateson's "application of Russell's theory of logical types" (Tomm, 1987b, p. 169), which involves communication among six levels of meaning in a circular, hierarchical relationship. The structures are conceptualized as having multiple levels of "embedded contexts" (Cronen et al., 1985, p. 206), which include: "content (of a statement), speech act (the utterance as a whole), episode (. . . the whole encounter), interpersonal relationship, life script . . . , and cultural pattern" (Tomm, 1987b, p. 168).

Described as "a self-referential network" (Tomm, 1987b, p. 169), a hierarchy in which "the meaning at each level turns back reflexively to influence the other" (p. 169) organizes the relationships between levels in a circular or reflexive way. Influenced by

this model, Tomm's reflexive questions function as "probes, stimuli, or perturbations . . . [and] only trigger reflexive activity in the connectedness among meanings within the family's own belief systems" (p. 171). According to Tomm, this suggests that it is the client who determines the particular effects of the questions, and "change occurs as a result of alterations in the organization and structure of the family's pre-existing system of meanings" (p. 171). Thus, change is not initiated by insight, but rather through the process of reflexivity.

According to Tomm (1987b), reflexive questions are "asked with the intent to facilitate self-healing in an individual or family by activating the reflexivity among meanings within pre-existing belief systems that enable family members to generate or generalize constructive patterns of cognition and behavior on their own*" (p. 171). This type of questioning "focuses more heavily on an explicit recognition of the autonomy of the family in determining the outcome" (p. 181).

For a few years, Tomm believed that the second-order perspective, grounded in the constructivist theoretical framework, was a good fit for him. However, he started to notice inconsistencies between his theory and the way he practiced therapy. Later, after being exposed to the writings of Kenneth Gergen, Tomm recognized that he "had not been a constructivist at all" (Tomm, 1998a, p. 178); rather, he was "a practicing social constructionist" (p. 178). Tomm (1998a) became aware that the "primary locus for a change in meaning" (p. 178) in the therapy process takes place within the therapeutic conversation. Secondary changes, such as those in individual "cognitive constructs . . . seemed to come later[, meaning] the change was initially interpersonal and secondarily intrapersonal" (p. 178). He attributed this newfound understanding to Maturana's theory

of knowledge, which asserts that "social interaction [is] the source of meaning" (p. 178). From this perspective, language is situated in the social domain of knowledge, an idea that will be explored later in this chapter.

Social Constructionism

The infusion of social constructionist ideas into the field of family therapy strongly influenced Tomm's therapeutic work. Described as "the creation of meaning through our collaborative activities" (Gergen & Gergen, 2004, p. 7), social construction is both simple and profound. It emphasizes that "everything we consider real is socially constructed" (Gergen & Gergen, 2004, p. 10). Influencing the family therapy field's transition from a modernist to a post-modernist perspective, social constructionism allows "for a multiplicity of perspectives and a methodology of discourse that fosters multiple descriptions and alternative explanations of human experience" (Tomm, 1998a, p. 173). Through the influence of social constructionism, the conceptualization and understanding of ideas about "the self, relationships, context, and responsibility" (p. 174) were significantly altered within the field.

Social constructionist theory posits that we create a sense of ourselves through language; "as we communicate with each other we construct the world in which we live" (Gergen & Gergen, 2004, p. 11). The concept of a self is constructed within social relationships, and "knowledge [is] . . . created and negotiated within communities of knowers" (Moules, 2000, p. 230). We participate in what Wittgenstein called language games, which are "forms of life" (Gergen & Gergen, 2004, p. 16) that use words "embedded within systems of rules or shared conversations" (p. 15). The words we use hold these different life forms together. At the same time, the life forms give meaning to

the words we use, thereby limiting our worlds. Social constructionists "do not embrace universal truths, or Truths with a capital 'T' . . . or Transcendental Truth" (p. 19). However, they do agree that there are truths with a small 't'—in other words, those that are issued and shared by a group or community, such that "claims to truth are invariably wedded to traditions of value" (p. 20). Difficulties arise, however, when claims of truth are considered Transcendental Truth, or when one group claims truth over another. Social constructionism liberates us from attempting to decide which values, beliefs, traditions, or ethics are real or True, as all perspectives are considered valid.

In the social constructionist framework, relationships are understood to be a process of active engagement and co-construction between those interacting, rather than simply a "passive outcome of interaction" (Tomm, 1998a, p. 174). Whereas context was previously understood as imposing limits and constraining us, this view opens up the opportunity for possibilities of co-creation. From this perspective responsibility—which was previously thought of as "individual culpability and blame" (p. 174)—is now considered more relationally, with more emphasis placed on how we co-construct meaning as a collective process that influences individual behavior.

Reflecting on his early training as a psychiatrist, Tomm (1998a) explains, "I was entirely oblivious at that time to my part in the social construction of professional privilege and patient vulnerability" (p. 175). Based on his modernist training, he was guided by an expectation to diagnose patients with mental disorders that "were assumed to exist within individuals" (p. 175), and then provide interventions to treat those disorders. However, he came to understand that close relationships have an immense influence on individuals' behaviors, which can easily be construed as "manifestations of

mental illness or mental disorder" (Tomm, 1999, p. 129). This led him to wonder whether his patients were actually "living within 'relationship disorders' instead" (p. 129). Based on this new understanding, Tomm came to identify certain patterns of interaction existing within the kinds of relationships that could be seen as the problem. I will further explore this idea in Chapter V.

According to Tomm (1998a), social constructionism creates possibilities to see and consider alternative realities, have a greater awareness of our available choices, and access numerous possibilities. When there is no need to claim "superiority of one's own tradition, one is invited into a posture of curiosity and respect for others" (Gergen & Gergen, 2004, pp. 21-23). This can be described as moving into a position of "both/and" (pp. 21-23). From a therapeutic perspective, this worldview compels us to attend to "issues of race, gender, social class, oppression, marginalization, and the power differential implicit in hierarchies and patriarchies" (Moules, 2000, p. 230).

What social constructionism does not do, however, is guide us in making therapeutic choices, which Tomm (1998a) considers to be "a major limitation" (p. 184). As he explains, "constructionism, in supporting a multiplicity of perspectives, fails to provide an ethical basis from which counsellors can select and act on specific versions or understandings of reality" (Strong et al., 2008, p. 179). Furthermore, it can be used with negative intentions, such as to construct "hatred for war, oppression for colonization, exploitation for accumulated wealth, and hedonism for immediate gratification" (Tomm, 1998a, p. 184). The effects of this are far-reaching and can be dangerous, compromising our humanistic values through "an insidious process of an increasing commodification of persons, relationships, and even meanings" (p. 184). Social constructionism, which

positions social interaction in the present moment, neglects the tremendous influence of constructs derived from rituals, heritages, and cultural traditions. In this way, "social constructionism remains vulnerable to cynicism and spiritual bankruptcy" (p. 184). Once he arrived at these conclusions, Tomm understood that he would need to find a basis for making ethical choices. For, this he turned to—and came to rely on—Humberto Maturana's theory of knowledge, which is "grounded in a scientific biology yet does not depend on objectivity" (p. 185). He came to use "social constructionism within the context of Maturana's *bringforthism*" (p. 185), providing him with "a rationale for ethical decision making" (p. 185).

Bringforthism

A term coined by Heinz von Forester, *bringforthism* is a perspective that serves to explain how Maturana's "reality emerged from [his] theory of knowledge or cognition" (K. Tomm, personal communication, August 16, 2019). This theory posits that humans, "as cognizing living systems, 'bring forth' ideas or entities through 'acts of cognition'" (K. Tomm, personal communication, August 16, 2019). As we draw a distinction about an entity, we bring it forth and can then act upon it, in relationship to it. In this process, we are responsible for the system engaged in making distinctions and bringing entities forward. This particular implication greatly influenced the evolution of Tomm's clinical practice. The bringforthist paradigm employs the methodology of recursive reflection, in which we reflexively examine "the distinctions we draw [and] the descriptions we generate, [as well as] explanations, intentions, choices, and actions through (internal and external) languaging and emotioning" (K. Tomm, personal communication, August 16, 2019).

Maturana (1970), whose work is an endeavor to challenge well-established *truths*, asserts that cognition is a "basic psychological and . . . biological function" (p. 5), which informs how we handle our world. As we aim to understand our worlds, through what we believe to be objective knowledge, we perceive our reality to be "systematic and predictable" (p. 5). Maturana questioned "the *a priori* assumption that objective knowledge constitutes a description of that which is known" (p. 5), which led him to consider what it means to know, and what is involved in the process of knowing.

Maturana (1970) sought to explain cognitive function from the perspective of the observer, who is also a living system. The observer determines that "an entity is an entity when he can describe it . . . [but] only if there is at least one other entity from which he can distinguish it and with which he can observe it to interact or relate" (p. 8). In this way, these observations and distinctions serve as a reference for oneself. Living systems, as homeostatic systems, are organized in a circular fashion. They cannot be considered by themselves, as they are part of something more. They "are units of interactions; they exist in an ambience" (p. 9).

Maturana (1970) addressed the temporal aspect of cognition, asserting that "the nervous system always functions in the present" (p. 18). He emphasized that it must be understood in this way, as the concepts of "past, future and time exist only for the observer" (p. 18). Maturana identified two key aspects of how the nervous system functions: one "refers to the domain of interactions defined by the nervous system (relations in general); the other . . . to the particular part of that domain used by a given species (particular classes of relations)" (p. 21). Thus, it is both the living system's structure and its organization that "define in it a 'point of view', a bias or posture from

the perspective of which it interacts determining at any instant the possible relations accessible to its nervous system" (p. 21). Observers are inherently organized by their nervous systems, and the input to that nervous system will depend upon what point of observation is chosen. According to Maturana, "The closed nature of the functional organization of the nervous system" (p. 25) is a result "of the self-referring domain of interactions . . . where every change of state of the organism must bring forth another change of state, and so on, recursively, always maintaining its basic circularity" (p. 25). In describing cognitive function, Maturana describes the circular organization of living systems as inductive and consistently functioning in predictive ways. Living systems continue to operate in repetitive fashion as long as what they do contributes to its function.

Maturana (1970) outlined two ways in which one organism can alter another's behavior. One is through interaction with it, whereby one's behavior "depends strictly on the following behavior of the other, e.g.: courtship and fight" (p. 27). The other is through communication, considered "the basis for any linguistic behavior" (p. 28). Here, the behavior of one is oriented toward "some part of its domain of interactions different from the present interaction, but comparable to the orientation of that of the orienting organism" (p. 27). This does not elicit an "interlocked chain of behavior" (p. 28), as occurs in an interaction. Rather, the "orienting interaction" in the first organism's behavior—regarded as "a communicative description" (p. 28)—generates a particular activity state in the organism's nervous system. This spawns "the domain of interactions with representations of behavior (interactions)" (p. 28), which appear to be independent of one another "within the niche: the linguistic domain" (p. 28).

As the organism spawns a "communicative *description*" (Maturana, 1970, p. 28) and interacts with its own representation of the description, it creates another description oriented in the direction of this representation. This sequence continues in a process that can "be carried on in a potentially infinite recursive manner . . . [, resulting in] the organism [becoming] an *observer*" (pp. 28-29). According to Maturana, this process is what generates discourse. When the observer orients "himself towards himself" (p. 29) and then develops "communicative *descriptions* that orient him toward his *description* of this self-orientation, he can . . . *describe* himself *describing* himself . . . endlessly" (p. 29). Accordingly, *self-consciousness*, created by this ongoing recursive process of self-description, is "a new domain of interactions" (p. 29).

For Maturana (1970), thinking is a "neurophysiological process that consists in its interacting with some of its own internal states as if these were independent entities" (p. 29). Behavior arises from both reflex mechanisms and thinking, although these two ways of generating behavior differ greatly. Actions resulting from reflexes are created from "a chain of nervous interactions that begins with a specific state of activity at the sensory surfaces" (p. 29). Although thinking, like communication, is also generated by a chain of nervous interactions that lead to behavior, it starts with the nervous system assuming a particular and distinct "state of activity . . . [regardless of how or in what] way it may have originated . . . [, reflecting] functionally its internal anatomical projection . . . onto itself" (p. 29). Maturana emphasizes that this process of thinking "is necessarily independent of language" (p. 30).

Language, or linguistic behavior, "is orienting behavior" (Maturana, 1970, p. 30). Maturana challenged the traditional idea of language as "a denotative symbolic system

for the transmission of information" (p. 30), or as merely a means to transmit something from one organism to another. When language is recognized as connotative, and it is understood "that its function is to orient the orientee within his cognitive domain without regard for the cognitive domain of the orienter, it becomes apparent that there is no transmission of information through language" (p. 32). Thought is not simply transferred from the one speaking to the one receiving. What must be occurring, then, is that "consensus arises only through cooperative interactions" (p. 32), in which all interactions between sender and receiver are dependent on the context, and "every linguistic interaction is thus necessarily context-dependent" (p. 33). As an "organism with a nervous system capable of interacting recursively with its own states" (p. 35), language, as an orienting behavior, "expands its cognitive domain by enabling it to interact recursively with descriptions of its interactions" (p. 35). This results in the emergence of natural language as a generative "new domain of interaction" (p. 35). According to Maturana (2002), "languaging," involves "living together in recursive coordinations of behaviors or doings" (p. 27). For him, "notions of communication and symbolization are secondary to actually existing in language" (p. 27), that is, to living "*in a flow of coordinations of coordinations of consensual behaviors or doings that arises in a history of living in the collaboration of doing things together*" (p. 27, italics in the original). Tomm embraced Maturana's reflexive definition of language as "a consensual coordination of the consensual coordination of action" (K. Tomm, personal communication, August 16, 2019). This notion significantly influenced his understanding of *internalized others*.

Learning, regarded as a historical process, occurs as organisms transform through behavioral experiences, "such that each mode of behavior constitutes the basis over which a new behavior develops . . . in a continuous process of becoming" (Maturana, 1970, p. 35). For the observer, learned behavior seems "justified from the past" (p. 35). It appears constant and determined, as if "the same behavior is reenacted on a different occasion" (p. 37). The observer makes this assumption irrespective of any other factors. However, since the system functions in the present, "learning occurs as an atemporal process of transformation" (p. 35). Appearing to emerge from changes of previous behaviors related to memory of a previous specific event, learning "lies in the cognitive domain of the observer as a description of *his* ordered experiences" (p. 37). Similarly, memory can also be considered "an allusion to a representation in the learning organism of its past experiences" (p. 37), as it is additionally "a description by the observer of his ordered interactions with the observed organism" (p. 37).

Finally, cognitive function is explored from the relationship with the observer. The cognitive domain "is the entire domain of interactions of the organism . . . [, which] can be enlarged if new modes of interactions are generated" (Maturana, 1970, p. 38). Such enlargement is considered to be "unlimited . . . and is a historical process" (p. 38). When our internal state is altered from an internal interaction, changes occur in our "posture or perspective . . . from which we enter into a new interaction" (p. 39). As observers, we "live in a domain of discourse, interacting with *descriptions* of our *descriptions* in a recursive manner, and thus continuously generat[ing] new elements of interaction" (pp. 39-40). We can interact with our own states as observers as well, and "through *describing* [ourselves . . .] in a recursive manner . . . , [become] a self-observing

system that generates the domain of self-consciousness as a domain of self-observation [lying] entirely in the linguistic domain" (p. 41). In this domain, there must be two organisms that interact "with comparable domains of interactions, so that a cooperative system of consensual interactions may be developed in which the emerging conduct of the two organisms is relevant for both" (p. 41).

The process of learning is not one "of accumulation of representations of the environment; it is a continuous process of transformation of behavior through continuous change in the capacity of the nervous system to synthesize it" (Maturana, 1970, p. 45). In his work, Maturana aimed to demonstrate how "*any understanding of cognition as a biological phenomenon must account for the observer and his role in it*" (p. 48, italics in the original). Within this cognitive domain, language provides a basic function of orienting behavior; however, not as a means of transmission of information, but rather as a means of creating "a consensual domain of behavior between linguistically interacting systems through the development of a cooperative domain of interactions" (p. 50). We interact through language "in a domain of *descriptions*" (p. 50) that are both "bounded because everything we say is a *description*, and infinite because every *description* constitutes in us the basis for new orienting interactions and hence, for new *descriptions*" (p. 50). This infinite, limitless potential for expansion of the cognitive domain occurs "through recursive *descriptions* and representations of [the observer's] interactions . . . , [where] creativity is the cultural expression of this unavoidable feature" (pp. 51-52). As they appear to the observer, what are considered to be "inconsistencies (*irrationalities*) in thinking and discourse . . . arise from contextual changes in the circumstances that generate them while the independent frame of reference provided by the observer remains

unchanged" (p. 52). Thus, according to Maturana, the notion "that reality [is] a universe of independent entities about which we can talk is . . . a fiction of the purely *descriptive* domain" (p. 52). As "there is no object of knowledge . . . , to know is to be able to operate adequately in an individual or cooperative situation" (p. 53).

Maturana (1970) emphasized the importance of considering the ethical implications of scientific work. Because human beings are "deterministic and relativistic self-referring autonomous system[s]" (p. 57), both ethics and morality emerge "as commentaries that he makes on his behavior through self-observation . . . [in which] man changes and lives in a changing frame of reference in a world continuously created and transformed by him" (p. 57). This means that "no absolute system of values is possible and all truth and falsehood in the cultural domain are necessarily relative" (p. 57).

Another ethical implication of Maturana's theory of knowledge involves the function of language. If language functions not as the transmitter of information, but as the creator "of a cooperative domain of interactions between speakers" (Maturana, 1970, p. 57), then each speaker operates from within their "cognitive domain where all ultimate truth is contingent to personal experience" (p. 57). As a result, "no one can ever be rationally convinced of a truth" (p. 57) that was not part of their own foundational belief framework.

The final ethical implication brought forth by Maturana (1970) relates to the theoretical concept that "man is a rational animal that constructs his rational systems . . . based on arbitrarily accepted truths (premises)" (p. 57). Therefore, one must choose "a frame of reference for his system of values" (p. 58). According to Maturana, humankind has avoided doing this by "resorting to god as an absolute source of truth, or to self-

delusion through reason" (p. 58), thereby justifying whatever one determines needs justification "by confusing the frames of reference" (p. 58). In the guise of appearing to be an act of choice, "the ultimate truth on which a man bases his rational conduct is necessarily subordinated to his personal experience" (p. 58). What Maturana sees as "the alternative to reason, as a source for a universal system of values, is aesthetic seduction in favor of a frame of reference specifically designed to comply with his desires (and not his needs) and defining the functions to be satisfied by the world (cultural and material) in which he wants to live" (p. 58).

To explain how we entered into objectivity, Maturana was "quite fond of talking about the story of Adam and Eve . . . when they took the bite of the apple from the tree of knowledge [and then] they knew that they were naked" (K. Tomm, personal communication, August 16, 2019). According to Maturana, this action, which is referred to as the "original sin," is what led us to treat one another as objects. From this point, we entered a way of seeing ourselves and each other from which we cannot extricate ourselves. Maturana determined that once human beings entered into language, they could not escape it. However, he asserts that we can:

> ameliorate its effects . . . of being in language and distinguishing each other as objects [by] 'tak[ing] a second bite from the apple,' so that we can come to know about our knowing, can reflect, and can learn to place objectivity . . . in parentheses" (K. Tomm, personal communication, August 16, 2019).

In doing so, we can ease the effects of objectivity.

Mendez, Coddou, and Maturana (1988) define a problem as "something that someone lives as a difficulty" (p. 144) and then subsequently identifies—or is identified

by someone else—as problematic. Thus, a problem is defined according to the way it is seen by that person or another "and [by] how he or she makes a social domain that accepts it" (p. 144). There are two components to this: the assertion and the acceptance. If these are not present, a problem does not exist. The components of both asserting a problem and accepting it exist within interaction, wherein the problem "entails a communication, and every communication entails a dynamic congruence between the participants who co-ordinate their behaviours through it" (Mendez et al., p. 145).

In the context of mental health in the West, the notion of pathology is brought forth. As agreement is reached between two parties, something more is operating in this context: a "peculiar consent of power" (Mendez et al., 1988, p. 145), whereby one listens and complies, agreeing to the power structure that exists within certain social systems. In our Western culture, such authority is conferred to certain individuals whom we assume to hold and "master an objective knowledge . . . [, enabling] them to distinguish among their fellow human beings those" (p. 145) considered psychologically healthy from those considered ill. These individuals hold the power to determine, by diagnosing and selecting treatment, what will occur "to others from the detached position of he or she who has a privileged access to an independent reality" (p. 145).

Mendez et al. (1988), questioning the notion of an objective reality, assert that "we, as biological entities, do not have access to an objective independent reality" (p. 149) and outline the consequences of what happens when objectivity is put "in parentheses" (p. 149). The first consequence is that "the real is specified by an operation of distinction . . . [with] as many domains of reality as there are kinds of operations of distinction" (p. 149). This eliminates the concept of objective facts, thus eliminating the

idea that we have privileged authority to a reality we hold as factual, which we can use to make decisions.

When we hold firmly to an objective reality, we believe there is only one single truth. In the context of disagreement or conflict, this means that both parties foster the idea that one must be right and, therefore, one must be wrong. With objectivity in parentheses, there is no need for one person to discount the other's viewpoint. Rather than disagree, the participants can acknowledge a misunderstanding, with each person assuming responsibility for their own view. As a result, conversation that leads to understanding becomes possible.

According to Mendez et al. (1988), this type of dialogue:

opens space for accepting the legitimacy of all different domains of existence but, at the same time, opens space for accepting the constitutive responsibility that every human being has for the world that he or she brings forth in coexistence with others. (pp. 150-151)

Multiple realities and multiple perspectives, identified previously as an assumption of social constructionism, resonate with Maturana's (1988) concept of *multiversa*, which refers to the existence of "many different, equally legitimate, but not equally desirable, explanatory realities" (p. 30).

From a clinical perspective, when we adhere to the notion of objectivity-in-parentheses, we no longer assume power over another human being. Individuals "may act *as if* objectivity is taking place [but know instead] what is assumed to be objective is something brought forth in language with a strong social consensus" (Tomm, 1986, p. 377). Understanding that psychological health and "illness are not absolute entities or

constitutive qualities of individuals" (Mendez et al., 1988, p. 151) enables us to consider

that certain social systems contribute to the bringing forth of these states of being. Human

beings, as ever-changing systems that transform based on their interactions, "change as

they change their manner of bringing them forth as a result of their behavioural changes"

(p. 151). This results in interactions that either stabilize or cause "disintegration of this

pattern" (p. 151). A pattern that leads an individual to be identified as experiencing

psychological pathology results from "social assessments of situations of emotional

contradictions that arise through the attempt to satisfy contradictory social expectations

that are accepted as objectively legitimate" (p. 152). In order to help move a client in the

direction of psychological well-being, a therapist must work toward interrupting these

patterns by first "negating their objective validity" (p. 152). However, this comes with

many considerations for therapists, as when we question objectivity, it becomes a central

premise of how we position ourselves and our clients within the therapeutic domain,

resulting in different social consequences.

If we live in a multiversa, then the client and therapist each live in their own

versum, and, together, they create yet another. When we put objectivity in parentheses,

given that "all domains of reality are equally valid . . . [and] everything that we human

beings do takes place in the constitution of a social domain, [this] makes every human

action an ethical statement that validates a manner of coexistence" (Mendez et al., 1988,

p. 153). The concept of multiversa influences the premise and practice of therapy,

because "as soon as a domain of reality is not brought forth, [as] the structure of the

entities that constitute it change, the systems that populated it disappear" (p. 154).

The family, considered "the most basic social network in terms of granting authority and power for deciding about the mental health of its members" (Mendez et al., 1988, p. 157), embodies its own unique *versa*, and, at the same time, brings forth the multiple realities of its individual family members. Mendez et al. (1988) define the family as:

> a domain of interaction of mutual support in the passion for living together in physical or emotional proximity generated by two or more people . . . either through explicit agreement or because they grow in it in the happening of their living. (p. 156)

Since it is defined by passion, it is also subject to disintegration "when this passion is lost, or when this passion cannot be maintained through separation" (p. 157) once certain conversational configurations disappear. When this occurs, what disintegrates is this particular kind of family; however, a new kind of family can evolve in its place. As long as the passion the family members have for each other is not lost, the creation of a new kind of family is possible, resulting in a greater diversity of change, both in conversation and in emotion.

When a family seeks therapy, what presents in the therapy room is generally not based upon the premise of objectivity in parentheses. According to Mendez et al. (1988), "what usually comes forth . . . is the operational dynamics of a closed network of conversations for mutual characterisations, accusations and recriminations" (p. 158). Family members take particular stances and make accusations according to their ideas about right and wrong. Such conversations, which espouse objective and absolute truths, "challenge the basic identity of the participants" (p. 166) and disavow each participant's

sense of identity, placing the speaker in a position of power, authority, and privilege. The listener, positioned to receive this portrayal of objective reality, responds with "recurrent emotional frustration" (p. 166), feeling as if he or she is failing to meet the expectations or values within this cultural domain. Through this pattern, "the family becomes a network of reciprocal expectations that cannot be fulfilled" (p. 167). This leads to feelings of rejection and resentment, as well as continued suffering. The "only escape . . . is the disintegration of the family, . . . the loss of the organisation (particular network of conversations) that defines it" (p. 167).

The therapist, placed in a position of attending to these conversations and listening to what "constitutes the organisation of the particular family brought forth by the consultees" (Mendez et al., 1988, p. 158), can help the family members make a shift toward objectivity in parentheses "only by participating with them in the interactions which will trigger in them structural change that will bring forth the disintegration of that organisation" (p. 158). In helping family members emerge from "their existential emotional contradiction" (p. 159), therapists help families bring forth something other than the current organization by which they have been bound. Whatever action the therapist takes—whether it is an interaction, a particular practice, or a statement—will necessarily take place "outside the domain of conversations that defines the . . . family . . . in the domain of existence of at least one of its members" (p. 159). In this way, change in the organizational structure will occur in one or family members, thereby interrupting the prior "characterisations, accusations and recriminations" (p. 159) and interfering with the continuation of these kinds of conversations.

One key focus for therapists is an understanding of what organizes family members as they bring forth what exists for them. Another is the discovery of what particular qualities family members have "that their integration as the family brings forth" (Mendez et al., 1988, p. 160). By fostering the disintegration of the family organization that presents itself to therapy, the therapist "return[s] the operational power" (p. 160) to the family members and opens up space for something new to evolve.

Mendez et al. (1988) assert that therapists should not be committed to changing their clients, but rather to "being a domain of interaction that allows the other . . . to put objectivity in parenthesis" (p. 160). Opening space for others carries with it an enormous responsibility—that of remaining aware of the power that the use of language has in eliciting change. Although the various systemic models—including strategic, structural, interactional, and constructivist—seem to "put an end to the notion of open-ended, lineal causation" (p. 167), they also claim "some pretended privileged access to an ultimate objective reality" (p. 167). Putting objectivity in parentheses offers a different way to approach clinical work, as it accounts for the fact that humans cannot "make any claim about an objective reality because such a claim can only be made in language, which is where reality arises" (p. 167).

As Mendez et al. (1988) assert, no individual can "claim any privileged access to an objective reality independent of the speaker as a criterion of validation of what is the case" (p. 167), be it normal or abnormal, related to health or to illness. When we put objectivity in parentheses, we recognize that no single perspective is more valid than the next, "because beyond them there is nothing; beyond language there are no things" (p. 168). Only by creating a new way of living with one another can family members make

the shift toward a new way of being. When we consider objectivity in this way, "we revert back in our social interactions to the basic emotional domain of mutual biological acceptance on which all socialisation rests" (p. 168).

The idea of objectivity in parentheses plays an important role in understanding the concept of power and how it thrives. Qualifying Maturana's statement "about [how] 'power is the effect, submission is the cause' . . . [, which implies] power rules through . . . submission" (p. 251), Tomm et al. (2001) acknowledged and clarified that it is the abuser, not the victim, who holds this responsibility. Understanding how we operate is key to guiding families in therapy, as the "rule of modern human societies is the concession of power under the assumption that he or she who has knowledge of an objective independent reality has an intrinsic right to it" (Mendez et al., 1988, p. 170). Embedded in this context of privileged access and power, family members remain in their respective positions, wherein "a claim to objective knowledge is an absolute demand for obedience" (p. 170). When objectivity is held in parentheses, a shift occurs for both the family members and the therapist. When we assume this stance, we operate "in a domain that always allows us honestly to move into a metadomain of coexistence under any circumstances of coexistence" (p. 171) and be aware of and responsible for our emotions. Assuming the position of objectivity-in-parentheses compels us to maintain "a position of personal or collective 'truth' with a consensual ethic, whereas objectivity leads us to appeal to some external 'Truth' with an authoritarian ethic" (Tomm, 1986, p. 377).

Tomm (1998a) was particularly compelled by Maturana's view that the generative process of love sits at the center of living systems' evolution, along with culture and human relationships. Maturana also asserted that language plays a key role "in bringing

forth specific distinctions in our consensual coordination of action with one another"

(Tomm, 1998a, p. 185). Social constructionism proposes this view as well. According to

Maturana, love "enable[s] the intensity of recurrent social interaction" (p. 185), which

allows language to develop in the first place. According to Tomm, love "might be the

most appropriate foundation for any therapy and for any social action for change" (p.

185). As Maturana explains, love is about "'acknowledging the legitimacy of the other in

relation to the self' and 'opening space for the existence of the other'" (p. 185).

  As therapists, we are taught that our first commitment in working with clients is

to do no harm. However, Tomm asserts that therapists who emphasize this too much may

find themselves immobilized. Accordingly, he asserts, "'First be honest in your caring,

and then do no harm'" (Bubenzer et al., 1997, p. 96). In order to do this, therapists must

have "positive feelings of human love towards the other" (p. 96), seeking to truly like our

clients so we can work with them in a more honest way. Tomm (1998a) describes his

way of practicing this by explaining, "I open myself to see the conditions and hear the

experiences of others and to act on their behalf as well as my own" (p. 185). For him,

therapy is a process of selecting the constructs "that bring forth more love" (p. 185).

  Maturana's concept of structure determinism implies that things are the way they

are, and that this must be so. This idea supports family therapists by reminding us that

everything in existence, including those experiences that might be "violent or horrible . . .

[, may exist as such] by virtue of some structure determined dynamics" (K. Tomm,

personal communication, August 16, 2019). Maturana's theory of knowledge underscores

the "theoretical impossibility of instructive interaction" (K. Tomm, personal

communication August 16, 2019), which means that as therapists, our efforts to change

clients are limited. Instead of attempting to change them, we must reposition ourselves to create contexts for learning to occur. In our work with clients, the importance of love is central to the therapeutic relationship. Making space for the existence of our clients is vital to the process of change.

When we maintain awareness of "mutual loving" (K. Tomm, August 16, 2019, personal communication) and its way of opening space for possibilities, we become more aware of the way in which judging and labeling restrains our clients, closes space, and decreases opportunities for being generative and creative. According to Tomm, Maturana's ideas about objectivity serve to remind therapists of the danger of assuming that there is an objective truth. By remembering this, we can avoid imposing our views on others, thereby decreasing "the probability of perpetrating violence by imposing [our] 'correct' views" on our clients (K. Tomm, August 16, 2019, personal communication). Holding objectivity in parentheses allows us to see all distinctions as equally legitimate. By realizing that these distinctions may not be equally desirable, we take responsibility for those that we bring forth, as well as for the actions that result from them. Accordingly, we recognize that the power of words, "a manner of mutual 'body touching'[,] . . . can be enabling and enlivening, or can be violent and oppressive" (K. Tomm, personal communication, August 16, 2019).

Unlike constructionism, bringforthism is "more participatory and less grandiose . . . [in that] we do not create the world, but . . . distinguish what we can from it; we are able to bring forth through living whatever our changing structures allow" (Moules, 2000, p. 231). As humans, we are biologically structured to interact with our environments through relationships using language. According to Moules (2000), Maturana's theory

reaches much further than "mind," to include "the process of life" (p. 231). As such, the

process of "'bringing forth' can be described as the breath of life" (p. 231).

CHAPTER IV: THERAPEUTIC INFLUENCES AND CONTRIBUTIONS

We contend that counsellors can benefit from attending closely to Tomm's

(and their own) communication with clients, regardless of their preferred

theoretical orientations.

—*Tom Strong et al.* (2008, p. 175)

In this chapter, I describe the therapeutic approaches and models that influenced

Tomm's work, and that he later contributed to through his own writings. Tomm both

learned from the models' original creators and presented with them in conferences and

workshops. I begin with the model that inspired Tomm's first major epistemological

shift, the Milan approach, and then discuss the reflecting team, a key component of

Tomm's clinical program at the CFTC. I then move to collaborative language systems

therapy and solution-focused brief therapy, as he incorporated components of each in his

work. Finally, I explore Tomm's affiliation and collaboration with Michael White and

David Epston, the originators of narrative therapy.

The Milan Team

When Tomm (1984a) first learned about the Milan team's method of family

therapy, he was "fascinated . . . [and found it] refreshing . . . to come across a radically

new way of thinking about and doing therapy" (p. 113). The process of discovering

different ways of asking questions and observing their interventions had a "dramatic

therapeutic impact" (p. 113) on Tomm, who integrated aspects of their model into his

own clinical work. He was inspired by the way the Milan group collaborated as a team,

exchanged roles, used the one-way screen, engaged in discussion, and established an

environment that fostered "interactive feedback" (p. 117). Tomm also retained their

stance of curiosity and method of circular interviewing, recognizing "how it is possible through your questions to understand systemic patterns of interaction and relationships so well" (Collins & Tomm, 2009, p. 112). He further extended their approach by distinguishing between circular and reflexive questions.

Prior to collaborating with the Milan team, Tomm made his first dramatic epistemological shift, from empiricism to constructivism, after reading Selvini Palazzoli et al.'s (1978) *Paradox and Counterparadox* (Bubenzer et al., 1997). Once he met the group, he was "profoundly affected" (Strong et al., 2008, p. 177) by their approach to therapy, most specifically by their concept of circularity, their view of families as self-correcting, and their commitment to "privilege family members' expertise and lived experience" (p.177).

For Tomm (1984a), the Milan approach exemplified the "complexity of the second-order epistemology which Bateson (1979) was working toward" (p. 124), as it positioned the therapist as both an observer of the therapeutic system and a participant within that very same interactional process. The therapist, as both a "participant-actor" (p. 124) and a witness of what is being observed, creates the possibilities for change.

Bateson had a significant theoretical impact upon the Milan team, informing their view of family systems as ever-evolving rather than homeostatic. His work influenced the idea that patterns themselves, which only *appear* homeostatic or stuck, are actually the "result of epistemological errors made by the family . . . [, who] follow an outdated or erroneous belief or 'map' of their reality" (Tomm, 1984a, p. 115). According to the Milan team, what families believe about their system is different than the behavioral patterns they demonstrate, as each is a distinct "level of logical type" (p. 115). The Milan

approach differentiates between the levels of meaning and action and emphasizes the influence of context on meaning. Interventions derived from this approach are geared toward generating new distinctions in thought and action that can help families design new patterns.

Influenced by the ideas of second-order cybernetics, Boscolo and Cecchin presented three principles they considered essential for interviewing families in systemic work: hypothesizing, circularity, and neutrality (Selvini Palazzoli et al., 1980). Of the three, circularity had the most significant influence on Tomm's clinical work, particularly his approach to interventive interviewing.

According to Selvini et al. (1980), circularity is "*the capacity of the therapist to conduct his investigation on the basis of feedback from the family in response to the information he solicits about relationships and, therefore, about difference and change*" (p. 6, italics in the original). The Milan group was committed to utilizing the principle of circularity to gather information from families "[while adhering to] the following fundamentals: 1. Information is a difference. 2. Difference is a relationship (or a change in the relationship)" (p. 6). The questions they asked were based on the supposition that "information lies in differences [or] that the meaning of a behavior is derived from its context" (Tomm, 1984b, p. 259).

A key part of the Milan method of working with families systemically involved asking questions for the purpose of eliciting information, thereby, distinguishing differences. Examples of these types of questions include: "hypothetical questions, behavioral effect questions and triadic questions (Tomm, 1984b, p. 259). Difference questions inquire about spatial differences between people and relationships, or about

views, values, thoughts, and beliefs. Temporal differences ask about different points in time in different combinations of the past, present, and future. Hypothetical questions ask specifically about the future, guiding family members to ponder other possibilities regarding behaviors or meanings. Behavioral effect questions seek to discern sequences and contexts of behavior, probing what this might mean for the broader interactional pattern. This type of question focuses squarely on what is observed, not on the intentions or feelings underlying the behavior. Although the intentions might be inferred, understanding the deeper meanings of these recurrent behaviors "are manifest more clearly in their effects rather than in the actor's conscious intent" (Tomm, 1984b, p. 260).

Triadic questions are used to gain information about a dyadic relationship from the perspective of a third person. The Milan team developed these questions as an invitation "to metacommunicate about the relationship of two others, *in their presence*" (Selvini et al., 1980, (p. 6), adhering to the "first axiom of the pragmatics of human communication" (p. 6), that individuals cannot not communicate. Tomm (1984b) emphasizes that triadic questions, unique to the Milan approach, challenge the commonly held belief "that therapists should encourage family members to speak for themselves" (p. 260). Asking triadic questions has a multitude of significant effects. Families who tend toward linear descriptions could utilize the implied circular structure of the questions as a novel invitation to think differently and become observers of their own system. A person asked to reflect on the relationship between two others becomes an "informant as outside observer" (p. 261), providing an alternate description than if they were inside the dyad. The triadic question can, as well, be posed to one member of the system regarding

another who is silent, asking them to surmise something about the other. This is known as "the 'mind reading' question" (p. 261).

Another Batesonian assumption incorporated into this model is "that 'mind' is social[;] mental phenomena are assumed to reflect social phenomena [and, therefore,] 'mental problems' [are considered] problems in patterns of social interaction" (Tomm, 1984a, 117). Bateson used the term *epistemology* to refer to "the way we know or understand the world around us, which determines how we think, how we act, and how we organize our existence" (Tomm, 1984a, p. 118). The Milan team understood the advantages of utilizing a circular epistemology, one that "orients the observer to focus on recursiveness in the interaction between parts of the system and to hypothesize about holistic patterns" (p. 118). This can be difficult to characterize in language, given that it "orient[s] us to think in lineal, possessive terms rather than circular, reciprocal ones" (p. 119).

In viewing family systems as evolving rather than homeostatic, the therapist assumes a role that is more facilitative than directive. Through trial and error, families try out new behaviors; when there is a "fit," this new way of behaving is repeated to "become 'coupled' [and to establish] a [new] pattern. Thus, therapeutic change, according to this model, involves changing 'existing patterns of change'" (Tomm, 1984a, p. 120). This is accomplished through the use of various interventions, some of which Tomm continues to incorporate in his present-day work. These include reframing, or the introduction of new meanings; prescribing actions or rituals, in which new meanings can be ascribed to new experiences; and using paradoxical interventions.

Caught up in constraining beliefs, families find themselves stuck in interactional patterns from which they cannot emerge. The paradoxical intervention "generate[s] confusion around those firmly held ideas and beliefs, [by] loosen[ing] the grip of the ideas" (Collins & Tomm, 2009, p. 109) and opening space for change to occur. This gives family members the opportunity to explore new ideas that can generate different behavioral patterns. As Collins and Tomm (2009) point out, "if these differences [make] a difference, in allowing the family to move forward, then the paradoxes [can be considered] very therapeutic" (p. 109). Tomm further explains that "confusion is useful[, as] it softens possibilities for new ideas to bubble up . . . [, and] if we can maintain alternate realities, we can provide more choices for possibilities" (K. Tomm, personal communication, August 12, 2019).

Therapists can prescribe suggestions that alter time, and thus change behavioral patterns. An example of this would be prescribing a sequence of contradictory behaviors. Paradoxical prescriptions transport opposing behaviors into the present and "eliminate sequential time by introducing simultaneity" (Tomm, 1984a, p. 122). Rituals prescribe a sequence of events and actions that serve to "create time" (p. 122). Tomm continues to use techniques that alter time; however, he considers his more "flexible" (p. 112) than those of the Milan team, as he co-constructs the prescribed rituals with families to suit their unique circumstances.

The therapist includes all family members in the process of prescribing rituals that do not explain or identify the behavior being targeted for change. For example, when using the *odd-day even-day* ritual, the therapist instructs one parent to respond to the child's behavior on odd days, and the other to respond on even days, emphasizing that the

parents are not to interfere with one another's interventions. On one day of the week, the therapist asks the family members to "behave spontaneously" (Selvini et al., 1978, p. 5).

Tomm conceptualizes this as an invitation to experiment, rather than a definitive instruction to alter interactional patterns. Although the ritual is prescribed, families are not directed to behave in a specific way. Tomm (1984b) does not expect that the family will follow through with the ritual; in fact, it "need not even be carried out to have a therapeutic effect" (p. 266). The ritual functions to present or punctuate "an important distinction . . . [, one that] could lead to contradiction of certain prevailing myths, belief, rules or meanings" (p. 266). By resolving this contradiction, family members can find other ways of behaving to create new patterns. Selvini et al. (1978) describe this intervention as "changing the rules of the game which is being played," providing the family with a different kind of experience that implicitly prevents the "usual transactional modalities" from occurring (p. 5). When the therapist utilizes the temporal dimension to prescribe distinct times for different behaviors, the result is frequently dramatic, "enabling the family to clarify chaotic patterns and to confront inherent but unrecognized contradictions" (Tomm, 1984b, p. 267).

Reframing aims to redefine the problem in either a positive or neutral manner and give it another connotation, such that the problem can be "construed as a solution" (Tomm, 1984b, p. 264). According to the Milan group, when a problem is reframed positively, it is given a *positive connotation*. This way of intervening "hooked [Tomm] on the Milan approach" (K. Tomm, personal communication, August 12, 2019). He considers it to be "one of the most useful aspects of the . . . approach[:] . . . the power of the distinction between good and bad" (Collins & Tomm, 2009, p. 109). As with rituals,

all family members are included, connecting the problematic behaviors to the family's context. A positive connotation challenges the entrenched ideas that hamper the family system, thereby freeing up opportunities for change. As the prescription is being offered, it is structured to include the important phrase, "for the time being," which serves to imply that the pattern of behavior can be temporary, creating space for change to emerge naturally.

Tomm first used positive connotation—"the belief that good intentions often underlie unhelpful responses" (Strong et al., 2008, p. 177)—with a patient suffering from anorexia and bulimia. At the time, he was working with the Milan group, and the reflecting team tasked him with delivering a specific message to the patient. The message completely contradicted what he had been taught in his medical training, which is that not eating leads to death. However, he went ahead with repeating the team's message to the patient. To the patient he said, that "the eating and vomiting '[is] good because it helps your parents worry'," and to the parents, [he] stated, 'It's good that you worry about your daughter.'" He concluded this intervention by telling the patient, "'The team believes you should continue in this work because it will protect your father from returning to his depression'" (K. Tomm, personal communication, August 12, 2019).

For Tomm (1998a), the positive connotation intervention was a way to challenge negative beliefs, create space for family members to develop new beliefs or meanings, and generate new patterns of interaction. Reflecting on his initial experience with the intervention, Tomm considered how he might have approached such a case as a physician, and what might have happened "if [he] had said, 'You should continue not eating because you'll starve to death'" (K. Tomm, personal communication, August 12,

2019). For him, this new approach represented the difference between "empirical truth and relational truth [and marked the] biggest single change" in his approach to family therapy, grounded in both social constructionism and bringforthism (K. Tomm, personal communication, August 12, 2019).

The Reflecting Team

Tomm considers the use of the reflecting team a "fascinating neurological process" (K. Tomm, personal communication, August 12, 2019) that occurs when clients listen to the team members fully and without distraction. The reflecting team approach that Tomm employs in his clinical practice at CFTC is built upon the foundational concepts described by Andersen (1987), with some variations.

Borrowing epistemological ideas from Bateson and Maturana, and drawing from the clinical work of the Milan team, Ackerman Institute, and Galveston Family Institute, Andersen (1987) developed his model on the premise that "it is the *observer* who generates the distinctions we call 'reality'" (p. 415). Maturana's ideas about the multiversa and reality as subjective and observer-dependent were foundational to Andersen's approach. Placing objectivity in parentheses, Andersen proposed that "one should think of the picture and its explanation more [as] *both-and* or *neither-nor,* and leave out the *either/or*" (p. 415). Andersen was influenced by Bateson's assertion that through the process of sharing various perspectives, individuals develop a different relationship to the world. Accordingly, therapists using Andersen's model are guided by an understanding that systems appearing to be immobile tend to function in a repetitive way, without sufficient new differences. The therapist "respect[s] the stuck system's resistance" (p. 416) and guard[s] against introducing questions that will be considered too

different from what the system's experience has been. In addition to the theoretical concepts that provided a foundational basis for his model, Andersen (1987) adopted certain clinical ideas he obtained from the Milan team, most notably that of maintaining a stance of neutrality and refraining from using negative connotation.

Andersen's (1987) therapy model operates on the premise that both "the interviewer and the family are each fully respected as autonomous systems" (Andersen, 1987, p. 418). The therapist identifies and clarifies the problem and attends to the observed patterns within the family system, using relational, difference, similarity, and hypothetical questions. Members of the reflecting team sit behind the screen listening quietly and respectfully as they generate their own ideas about what they are observing (Andersen, 1987). Toward the end of the session, the therapist invites the family to listen to the team's reflections. With the family's consent, the team members behind the screen turn on their lights and sound, and the therapist and family turn off theirs. The team members offer their reflections spontaneously, in a tentative and speculative manner, and "not [in the form of] pronouncements, interpretations, or supervisory remarks" (p. 419). Taking care to use only positive connotation and avoid "every normative judgment" (p. 423), the team "remain[s] positive, discreet, respectful, sensitive, imaginative, and creatively free" (p. 423).

Reflecting team members trained in Andersen's approach share their most significant and relevant ideas, based solely on what they observed during the session. They are trained to discuss their ideas in terms of *both-and* or *neither-nor*, which is distinct from the *either/or* framework that family members tend to use in session. As the team generates ideas, the family members listen, free to determine which, if any, of those

ideas are meaningful for them. The team members conclude their reflections, the light and sound are switched back in both settings, and the interviewer asks the family members whether anything in particular resonated with them.

Andersen deviated from the reflecting team approach being used at the time by having the reflections take place in the family's presence. Rather than hypothesizing about clients in their absence, Andersen's teams were encouraged to treat them as equals in the therapeutic relationship, seeing the therapist as simply a part of the larger system. Andersen (1987) believed that when different perspectives are allowed to emerge, an exchange of differences is generated, that, when shared, creates a new and expanded view—"an ecology of ideas" (p. 415).

Tomm notes that the Milan group "privileged the team, whereas Andersen privileged the family" (K. Tomm, personal communication, August 12, 2019). Making some changes from Andersen's original method, Tomm has reflecting team members sit in a semi-circle facing the family on the other side of the two-way screen. The reflection process begins with the team members introducing themselves to the family. They then turn their chairs inward toward one another in a circle, positioning themselves intentionally to be a focus of observation for the family. This is designed to allow "more of their mental energy to flow into deeper listening" (Couture & Tomm, 2014, p. 71). The team members ensure that they speak about each family member as they acknowledge and affirm what they noticed in the session. This creates a positive foundation upon which more challenging comments can be offered. In addition, these positive offerings are designed to help team members "overcome their own problem-focused noticing habits" (Couture & Tomm, 2014, p. 71). As in Andersen's model, reflecting team

members in Tomm's approach are encouraged to freely speak about what they noticed. They may choose to share personal life experiences, if certain relevant memories are re-activated while observing the therapy session, which allows the family members to "see team members as human beings in a common journey of living" (p. 71).

As in Andersen's model, comments are offered tentatively, providing family members with a choice to accept or reject an idea. While the family members are actively listening to the team members' reflections, Tomm intentionally avoids looking at the family members or attempting to observe their reactions, as he does not "want to put them under the gaze and . . . become self-conscious . . ." (K. Tomm, personal communication, August 15, 2019). Although he recognizes that this "is limiting in terms of getting information[, he asserts that] it is better therapeutically" (K. Tomm, personal communication, August 15, 2019). Following the team's reflections, the lights and sound are switched so that the focus is back on the family, and the therapy session resumes. The therapist then asks each family member—starting with the youngest—about their reactions, including what resonated and what was useful.

Collaborative Language Systems Therapy

Despite Tomm's work being highly acclaimed for his use of collaboration with clients, he does not consider himself to be well-versed in the practice of collaborative language systems therapy. Nevertheless, alongside the models of solution-focused therapy and narrative therapy, he acknowledges Anderson and Goolishian's collaborative approach to be another contribution to his practice of co-constructing preferred realities (Tomm, 1998a).

In Anderson and Goolisihian's (1988) model, the therapist's role is to join with the system in conversation, creating language and meaning together "to keep the dialogue going toward *dis-solving the problem and the dissolving of the system* [constituted by the problem]" (p. 373, italics in the original). Viewing human systems as linguistic systems of language and meaning, therapists recognize that understanding is generated through interaction, as "we live with each other, we think with each other, we work with each other, and we love with each other" (p. 377). Thus, it is through language that shifts in meaning can take place.

Anderson (1997) describes her philosophical stance as a collaborative approach—a partnership between the client and the therapist in which the "client is the expert on his or her life experiences" (p. 95), and the therapist "brings expertise in the area of process[,] . . . engaging and participating . . . in a dialogical process of first-person story-telling" (p. 95). All of the participants in the therapeutic system "assume a reflective listening position in which inner dialogue becomes possible" (p. 126). Whatever each member contributes is considered important and worthy, creating an environment that invites further expansion of the story.

According to Anderson and Goolishian (1988), a therapeutic system is comprised of those engaged in dialogue about the problem. Hence, the social structure does not distinguish "the problem;" "the therapy system . . . is distinguished by 'the problem'" (Anderson & Goolishian, 1988, p. 371). Problems are created through a co-evolutionary process "that exists in ongoing dialogical communication" (p. 379). Since change is constant, "no 'problem' will exist forever" (p. 379).

An important concept in collaborative learning systems is the position of "not-knowing," which is both "an attitude and [a] belief—that a therapist does not have access to privileged information . . . [, and, therefore,] always needs to be in a state of being informed by the other" (Anderson, 1997, p. 134). In this approach, the therapist must remain aware of their own discourses and assumptions, constantly calling them into question and staying careful not to value their own knowledge more than the client's. As part of the system, the therapist maintains a *not-knowing* position, remaining open to change and willing to assume the risks that accompany such openness. As Anderson (1997) explains, "Knowing and understanding . . . are always *on the way*" (p. 135), in a process of becoming.

For the therapist to assume a not-knowing stance, they must sincerely be interested in learning how clients make sense of their circumstances from their perspective. A cornerstone of collaborative language systems therapy, the not-knowing stance "privilege[s] a social deconstruction process by questioning the certainty inherent in the family's prevailing views" (Tomm, 1998a, p. 179). Through the therapy process, views that are less limiting get more of an opportunity to flourish.

Therapists using Anderson and Goolishian's (1988) approach ask questions about "multiple and contradictory ideas simultaneously" (p. 382). They remain non-judgmental, show interest in everything the client contributes to the conversation, use the client's own language, demonstrate to the client that they are listening and understanding, bestow respect, and help move the client in the direction of collaborative dialogue. They construct new questions according to the answers they receive, so the problem "evolves new meaning, interpretation and understanding, . . . [until it] *dis-solves*" (p. 383). Since

the problem is situated in language, possibilities for change can be found in what is not being discussed, in what has not been expressed, in "the *not-yet-said*" (p. 381).

The collaborative language systems approach "shifts the world of therapy from the world of pathological social structure to the world of meaning[,] . . . a shift to the world of conversation and dialogue" (Anderson & Goolishian, 1988, p. 390). The therapeutic process is one of creating a new space for collaborative conversation, such that the system involved in the language of the problem engages in discourse that moves toward dissolution of the problem. Tomm (1998a) regards this model as a valuable contribution to the field of family therapy, as it relies upon the "assumption that the social process of a therapeutic conversation can be used to co-construct realities of competence and 'wellness', instead of diagnostic deficits and mental 'illness'" (p. 179).

Solution-Focused Brief Therapy

Solution-focused therapy "privileges a shift in attention away from problems to client resources and competencies that constitute *exceptions* to the problems" (Tomm, 1998a, p. 179). The solution-focused therapist guides the client to notice exceptions to their problems, so a process of selection can begin as "the basis for a reconstruction of the client's experience of self and a basis for a different course of action" (p. 179).

Bubenezer et al. (1997) point out that solution-focused work constitutes "a shift from looking at the bottle as half-empty to seeing it as half-full" (p. 95). However, this shift involves more than simply putting a positive spin on clients' situations. It is a matter of co-constructing "new phenomena rather than just shifting the focus" (p. 96).

Narrative Therapy

Tomm's collaboration with Michael White began in 1984 (K. Tomm, personal communication, August 15, 2019). The relationship between the two theoreticians and clinicians mutually enriched and influenced their developing ideas and clinical practice. Tomm was significantly influenced by Michael White's narrative therapy—most notably, his ideas about externalizing and power—and he wove them inextricably into his ethical stance. For Tomm, White's method of externalizing—"an approach to therapy that encourages persons to objectify, and at times, to personify, the problems that they experience as oppressive" (White, 1989, p. 5)—is "a major innovation in the field of psychotherapy" (Tomm, 1993, p. 64) that enables empowerment. When a problem is externalized, it "becomes a separate entity and thus external to the person who was, or the relationship that was, ascribed the problem" (White, 1989, p. 5). By placing the problem outside of the person, it is rendered "less fixed and less restricting" (p. 5).

White's (1989) work was heavily influenced by "the 'interpretive method' [inspired by Gregory Bateson's ideas] and . . . Michel Foucault's analysis of dominant cultural practices in Western societies" (p. 6). The interpretive method encompasses how people understand the world and how "it is not possible . . . to have an appreciation of objective reality," as "knowing requires . . . [people to] interpret their experience of the world [via] the ascription of meaning" (p. 6). People ascribe meaning to their experience largely through the stories they hold regarding their lives. Externalization provides a way for people to move away from the dominant stories that shape their lives, enabling them "to identify previously neglected but vital aspects of lived experience . . . [, otherwise known] as 'unique outcomes'" (p. 7).

Drawing on Foucault's work, Michael White emphasized the oppressive nature of "knowledge systems like medicine" (Tomm, 1989, p. 54), which change people into patients, or "dehumanized 'subjects,' through scientific classification under 'the gaze'" (p. 54). Establishing "a protest against the use of knowledge as power" (Tomm, 1993, p. 64), White wrote about the privilege bestowed upon professionals to label and diagnose, echoing Foucault's warnings about the "totalizing effects . . . and exclusion practices that accompany the labels" (p. 64).

According to Tomm (1993), Michael White's "courage to protest that which he consider[ed] oppressive and unfair" (p. 62) was one of his most venerable qualities. White contested injustices that he saw at the individual, institutional, community, and cultural levels. By aiming his "protest against problematic beliefs and practices" (p. 63), White effectively separated those beliefs and practices from the person, thereby creating the opportunity for the person to align with him in the protest against the problem. Tomm emphasizes that in the externalization of a problem, injustice, habit, or belief, there are two simultaneous protests that take place: one directly against the issue itself, and the other "an injunction against allowing the self to submit to the problematic beliefs of habits" (p. 64).

The process of externalization can be extended to help people "challenge other practices that are 'objectifying' or 'thingifying'. . . persons and their bodies" (White, 1989, p. 22). Most prevalent "in Western societies, these practices of objectification are very pervasive" (p. 22). Externalization assists in the process of "de-objectification of [clients], of their bodies, and of each other" (p. 22), thereby liberating them to "act independently of the problem" (p. 22). As part of the process of deconstruction, of

separating the person from the problem, externalization explores the "archaeologizing aspects of externalized problems[,] disclosing patterns of unfair recruitment" (Tomm, 1993, p. 71).

According to White (1989), families in therapy present "a 'problem-saturated description' of family life . . . [, one that becomes] a 'dominant story of family life'" (p. 5). In the externalization process, family members gradually become less identified with the problem, which allows them to entertain options and develop descriptions of themselves and each other that do not include the problem. This enables them to create "an alternate story" (p. 5) about their lives. According to White, this process is helpful because it diminishes conflict between family members; it "undermines the sense of failure that has developed" (p. 6); it opens space for family members to work together and "unite in a struggle against the problem . . . [and] escape its influence in their lives and relationships" (p. 6); it creates space for new possibilities for people to reclaim their lives from the problem's influence; and it allows family members to "dialogue, rather than monologue, about the problem" (p. 6).

To help family members develop "new and 'unique re-descriptions' of themselves" (White, 1989, p. 7), narrative therapists ask questions designed to elicit the process of externalization. For example, "relative influence questions . . . map the influence of the problem in their lives and . . . map their own influence in the 'life' of the problem" (p. 8). "Sphere of influence" (p. 8) questions help reveal the effects the problem has had on different individuals and their relationships. The conversations generated from such questions highlight the "life" of the problem, which "bring[s] forth information that contradicts the problem-saturated description . . . and assists persons to identify their

competence and resourcefulness in the face of adversity" (pp. 9-10). Narrative therapists draw attention to their clients' "efforts to call into action their own resources to limit "the 'power' of the problem over them" (Tomm, 1989, p. 55). In doing so, they endorse clients' abilities and reduce blame and guilt by helping them identify what they have already been doing effectively.

Tomm (1998a) has pointed out that externalization releases clients "from the constraining effects of socially constructed descriptions of themselves and their relationships" (p. 178). The aim is for the clients to see themselves "as oppressed by the views that contribute to negative identity" (Tomm, 1998a, p. 178). As they recognize this entrapment, they start moving toward freeing themselves of the oppression. Through a process of re-authoring, a new story is constructed that supports a healthier alternative identity. The therapist and client collaborate in a process of creating a preferred narrative identity that is socially co-constructed.

Narrative therapists engage in a process "of deconstruction, bifurcation, and reconstruction" (Tomm, 1993, p. 71) that involves "a systematic separation of problematic attributes, ideas, assumptions, beliefs, habits, attitudes, and lifestyles from the patient's dominant identity" (Tomm, 1993, p. 55). Rather than assuming the individual to be the problem, narrative therapists understand that "the problem . . . is the problem" (White, 1989, p. 6). According to Tomm, protest is a recurrent theme in White's work—protest against the problem and its recruitment of the individual. He considers the reconstruction process to also be "grounded in protest . . . [,] based on movement towards liberation and autonomy, which implicitly is always away from the oppression of unjust cultural practices and beliefs" (Tomm, 1993, p. 72).

In narrative therapy, clients are invited "to take action against the externalized problem" (Tomm, 1989, p. 55). This fosters a personal agency that they experience "when they internalize conversations about themselves that reflect the richness of their lived experience" (Adams-Westcott, Dafforn, & Sterne, 1993, p. 261). According to Tomm (1989), this process embeds "the notion that the patient does have choices, and that the patient is an active agent in the course of their own lives" (p. 56). The internalizing of knowledge, which happens secondarily in the narrative therapy process, is central to Tomm's practice of internalized other interviewing.

Bifurcation questions are used in narrative therapy to "creat[e] a bifurcation (or branching) with reference to alternative meanings and alternative directions of movement" (Tomm, 1993, p. 67). Although White did not describe this type of question as causing "emotional realignment" (p. 67), Tomm considers it a key aspect of bifurcation questions, as it generates movement in a particular direction and offers a way to co-construct a foundation for making therapeutic choices (Tomm, 1993). Tomm (1989) emphasizes the importance of inviting clients to see that they have a choice: They can choose to remain influenced by the problem or to "*reject . . . the invitation to submit to the dictates of the problem*" (p. 56, emphasis in the original). Even though it is presented as a choice, Tomm cautions against applying any sort of pressure on a client to choose a certain course, which could reactivate blame and guilt.

Tomm once presented on externalization at a workshop in Japan, describing externalization as a way to "linguistically separate" an "oppressive and restraining" problem from a person (Tomm et al., 1990, p. 104). In response to this description, participants at the workshop explained that Japanese culture does not promote

"confrontation and struggle against" (p. 104) problems; rather, it prioritizes "compromise and co-existence with problems" (p. 104). An illustration of this can be found in Japanese folklore, which depicts a "mythical 'bug' or 'worm'" (p. 104), the *Kan-No-Mushi*, that resides within each growing child and assumes responsibility for a child's troublesome behavior. Hearing this, Tomm considered the folkloric notion to be "a possible 'inner externalization'" (p. 104), as the child is deemed separate from the problematic behavior. The concept of the *Kan-No-Mushi* "makes it easier for the adults to maintain positive attitudes towards the child while at the same time acknowledging the misbehavior" (Tomm et al., 1990, p. 105). The child is drawn into the problem-solving conversation to explore ways to settle the *Kan-No-Mushi* and "generate some sort of peaceful coexistence with its temper . . . [with a] focus . . . on achieving a compromise with [it as] something . . . one . . . learn[s] to live with for life" (p. 105).

Tomm noted the parallels between the notion of the angry worm residing within a child in Japanese culture, and the description and personification of Michael White's "'Sneaky Poo,' the label he created to depict the excrement of an encopretic" child (Tomm et al., 1990, p. 105). Both ideas serve to separate the problem from the person's identity using "linguistic distinctions" (p. 105).

Although both share characteristics of externalization, such as decreasing shame and guilt while having the person assume responsibility for how he or she interacts with the problem, the externalized problem is located differently. While White's process positions the externalized problem outside of the person, the Japanese concept externalizes the problem within the person. White's "outer externalization supports a pattern of languaging in which the problem is talked about as if it eventually could be

defeated, escaped and left behind. Conversations about conflict, power and control tend to prevail" (Tomm et al., 1990, p. 105). In contrast, the concept of inner externalization talks about the problem "as if some kind of ongoing co-existence may be necessary" (p. 105). Thus, the conversations this orientation promotes are more apt to denote "reflection, compromise, and cooperation" (p. 105), which may be a useful way to externalize those clinical issues that are considered to be more biological in nature (i.e., schizophrenia). According to Tomm et al. (1990) this is already the case in "some Western conversations . . . [in which] the person is not regarded as the problem, the genetic makeup or the 'biological imbalance' is construed as the problem" (pp. 105-106).

According to Paré and Lysack (2004), externalizing conversations generally "establish an adversarial relationship between persons and problems . . . [,] which can create space for constructing a sense of personal agency" (p. 7). However, the authors caution that "it is only as helpful as its *fit* for the person" (p. 7). As the person chooses to take an adversarial position or connect with the problem in a different way, progress in therapy becomes determined by the way the problem is spoken about. Clients, immersed in their problems, see them "from a self-enclosed monologue," mired in their own perspective and reality (p. 11). As part of the therapeutic process, narrative therapists work "to disrupt and disempower the taken-for-granted 'truths' or constraints" (p. 11), thereby opening space for additional voices to participate in the conversation. As people are able to "separate from oppressive stories[, they are able to] take a reflecting position with themselves" (Tomm, as cited in Adams-Westcott et al., 1993, p. 264). They are then free to move away from the constraining monologue and toward a dialogue that considers other voices and perspectives. However, Pare and Lysack point out that "no discursive

process is inherently dialogue-promoting. Sustained dialogue is a dynamic flow . . . [, a] process [that] is never finalized" (p. 14).

According to Tomm (1993), White's "exoticizing use of language" (p. 74) served as a unique and effective feature of the externalization approach. White possessed "an extraordinary gift in being able to turn a common . . . word or phrase into something peculiar and odd" (p. 74), a quality that seemed to capture his clients' attention. As Tomm explains, using language in such a way "opens space for us to become more aware of certain nonconscious aspects of the familiar" (p. 74). In therapy, it enables clients to make choices that will have greater meaning for their lives.

When practicing externalization, therapists may have a tendency to hold high expectations for change, which can lead to feelings of hopelessness and failure. To counter this, therapists are trained to encourage small gains and propose to clients that small setbacks are a normal part of the process. Regarding the trajectory of progress, Tomm emphasizes that the direction is more important than the presence of large or frequent improvements. He suggests that once constructive changes have taken place, therapists must respond to them so they "become part of [the client's] healing identity" and get incorporated into "the new emerging self" (Tomm, 1989, p. 56). To support this process, therapists are encouraged to ask future-oriented questions that help clients envision how the new changes might look to them and others at a later time.

Tomm introduced the use of reflecting teams to Michael White, who eventually incorporated them into his approach. However, the two implemented this practice in different ways. White's teams began their reflections by identifying what they saw as unique outcomes for the family members, specifying their observations of "preferred

developments in their lives and relationships" (Tomm, 1993, p. 72). Team members then

surmised what the meanings might be behind the developments, to create a sense of

mystery and pique the family members' curiosity.

Tomm's reflecting teams tend toward more flexibility and greater spontaneity.

Although he agrees that providing affirming reflections is valuable, Tomm considers it

restrictive to focus solely on "preferred developments and their meaning" (Tomm, 1993,

p. 73). In addition, he sees the reflecting team as useful in deconstructing and bifurcating,

rather than merely serving as part of the constructing process. Offering deconstructing

reflections in a tentative manner provides family members the option to either reject or

accept what the team members offer. In this more organic, less structured approach,

Tomm encourages his team members to develop their reflections by staying "grounded in

their intuitive emotional experiences while observing . . . and to leave it to other team

members to reconstruct [each other's] contributions to become more therapeutic" (p. 73).

This way of guiding team members leaves space for unforeseen possibilities to arise.

Despite the usefulness and influence of narrative therapy in Tomm's therapeutic

work, he has expressed concerns about various aspects of the approach and its practice,

particularly the potential for "getting disconnected from the body" (Bubenzer et al., 1997,

p. 96). Both White and Tomm oppose assumptions about knowledge as objective "truth"

and embrace a social constructionist view. White described the epistemology underlying

his emphasis on the re-storying of people's lives "as 'constitutionalist'" (Tomm, 1993, p.

74). Tomm, in contrast, considers himself "a 'bringforthist' . . . [, with a] focus on

enabling persons to bring forth coherent descriptions of experience that have therapeutic

potential" (p. 74). This highlights a major difference in what each approach emphasizes.

White's work is focused on stories about people's lives and experiences, while Tomm (1993) focuses "on lived experience" (p. 75). Tomm asserts that narrative therapists are at risk of becoming over-involved in stories, resulting in a disconnection from experience. He has cautioned about the importance of remaining "grounded in experience" (Bubenzer et al., p. 96), considering disconnection to be "quite trivializing of experience and tyrannizing of autonomy" (p. 96).

Despite its broad applications, externalization, also has limitations. Not all problems are considered appropriate for externalization, specifically those involving sexual abuse and violence. Tomm cautions against using externalization when there is any violence taking place within the system (Collins & Tomm, 2009). Therapists should avoid encouraging clients to externalize "the attitudes and beliefs that appear to compel the violence, and those strategies that maintain persons in their subjugation" (White, 1989, p. 12).

Tomm (1989) has made sense of White's concept of externalization using Maturana's ideas, specifically his theory of cognition, which explains "how the mind arises through human interaction and 'languaging'" (p. 54). According to Maturana, the mind is not in the brain, but "in the linguistic interaction among human actors" (Tomm, 1989, p. 54).

Whereas White's interest in pursuing injustice drew from the work of Foucault, Tomm was drawn to the work of Maturana. Tomm (1993) notes consistencies between the two theorists' ideas, including that:

Maturana's . . . explanation of language [demonstrates] how Foucault's notion of 'positive power' is . . . constitutive . . . [,] as all observing, all human knowing,

and all aspects of reality . . . are constituted in language[, as are] the tyrannizing

effects of objectification through language. (pp. 77-78)

To make the point that Maturana is "less pessimistic" (Tomm, 1993, p. 77) than Foucault, Tomm asserts that the greatest difference between the two is Maturana's "emphasis on 'love' as a biological phenomenon that makes it possible for observing and language to emerge among humans in the first place" (p. 77).

Tomm (1993) was impressed by Michael White's stance regarding his power and its influence on clients; however, he observed that this was not made equally apparent in White's written work or presentations. He suggested seeing in White "a readiness to openly and explicitly apply his critique of knowledge and power to his own use of knowledge and power during his teaching" (p. 64).

Tomm (1998a) points out that while narrative therapy addresses issues of social justice more fully than the collaborative or solution-focused approaches, the narrative metaphor might unintentionally constrain the development of a social-justice sensibility. Because the narrative is directed toward a story, the text of the narrative is "implicitly privilege[d]" (p. 182). Intently focusing on the story can cause the therapist to inadvertently disregard the politics of the situation or issues of social injustice.

For Tomm, the narrative metaphor does not hold a place of prominence. As he explains, a story is "a concatenation of internalized conversations . . . [,] the complexity [of which] renders it more distant from experience than a conversation that may be a component of the story" (Tomm, 1993, p. 75). Thus, conversations are more important for Tomm than stories. The narrative idea "that 'stories provide the structure of life'" (p. 75) is an assertion that Tomm struggles to adhere to, especially considering his

background as a physician. As he explains it, "such claims render our bodies passive and docile" (p. 75).

  Despite the differences between the ways in which Tomm and White conceptualize therapy, Tomm incorporates numerous components of narrative practice in his approach, including White's concerns about ethical practice and his commitment toward "increased transparency and greater personal authenticity" (Tomm, 1993, p. 80). Like White, Tomm believes in "diminish[ing] the mystique of therapy and reduc[ing] the power differential between therapist and client" (p. 80).

CHAPTER V: ASSESSMENT AND THE THERAPEUTIC INTERVIEW

We touch each other with our words . . . we want to formulate and use the

kinds of questions that are more likely to be . . . caressing one another in

ways that are enabling of people's wellness.

—*Karl Tomm* (personal communication, August 14, 2019)

Through his years of exploring and coming to understand how families work,

Tomm (2014a) wove together threads from various theories that contributed to his current

framework for assessing families and conceptualizing them as interpersonal systems. In

the first section of this chapter, I present Tomm's position on the Diagnostic and

Statistical Manual (DSM) and delve into the alternative assessment method he developed:

the IPscope. In the second section, I discuss Tomm's highly influential work on

interventive interviewing.

Anti-DSM Stance and the IPscope

Early in his career as a psychiatric resident, Tomm accepted the status associated

with his professional role. He saw himself as having "expert" knowledge and expected

his "patients to defer to [his] 'superior' knowledge and skills" (Tomm, 1998a, p. 175).

But as his thinking evolved, he came to see this stance as a means of taking skills *away*

from his patients, as an invitation for them to develop a dependency on him. At the same

time, he became "increasingly concerned about the inadvertent pathologizing influence . .

. of. . . the [Diagnostic and Statistical Manual of Mental Disorders (DSM)]" (Tomm,

1990, p. 5). He viewed it as "one of the major pathologizing documents in our culture"

(Strong et al., 2008, p. 175). He saw diagnostic labels as disempowering, believing them

to "confer problem causality" (Strong et al., 2008, p. 179).

Tomm (1990) began to develop concerns over the DSM becoming "such an authoritative document for classifying and labeling persons with mental problems" (p. 6), accepted not only by most systems of mental health, but also by third party payers, who require a psychiatric diagnosis for reimbursement. Among the many entities who rely on the DSM, none of them appear to consider the effect that psychiatric labeling has on those "who have already been socially and psychologically traumatized" (p. 6). Categorizing people in this way causes "permanent stigmatizing patterns of social interaction in the human network of relationships in which a person so labelled is embedded" (p. 7).

While running his family therapy program at The University of Calgary in 1988, Tomm faced an administrative challenge. The university instructed him to begin using diagnostic labels from the DSM-III to determine the admission eligibility of children and adolescents presenting at his clinic. Concerned that such labels would become "internalized as part of the child's identity" (Tomm, 1991, p. 1), Tomm refused to use "a diagnostic means that contradicted the therapeutic ends" (p. 1). Assuming that patterns of interaction shape experience and mental health, he noted that some patterns are "pathologizing," while others "have 'healing' or 'wellness' effects" (p. 1). This idea prompted Tomm to design a new psychiatric assessment approach based on interactional patterns. The instrument he developed, which he named the Interpersonal Pattern Scope (IPscope), focuses on both pathologizing interpersonal patterns (PIPs) and healing interpersonal patterns (HIPs) (Tomm, 2014c).

Tomm acknowledges that "understanding individual families can be extremely complicated" (K. Tomm, personal communication, August 13, 2019), since assessments

occur at three different levels—the biological, psychological, and social—that each include both intrapersonal and interpersonal effects. A comprehensive assessment needs to look at families "in terms of connectedness between those levels" (K. Tomm, personal communication, August 13, 2019). According to Tomm, families must be assessed at the social level in terms of four key dimensions need to be assessed: structure, development, functioning, and social cultural context.

Assessing family systems is also difficult, because when we observe them we can only see the skin-bound individual family members. The relationships among the family members, a critical focus to understanding family systems, are not as easily observed. Tomm (2014a) first attempted to assess family relationships using "the cybernetic metaphor of feedback loops" (p. 14), creating a system for mapping sequences of interaction that he labeled the Circular Pattern Diagramming (CPD) model (Bubenzer et al., 1997; Tomm, 2014a). However, he "became aware [that he was] thinking in terms of multiple individual family members rather than in terms of the interactions between and among them . . . [,] slipping back to old habits of looking at individual persons" (Tomm, 2014a, p. 14). This is partly due to the fact that in the CPD, the people interacting are incorporated into the diagram, whereas interactional patterns occur "in the interpersonal space between people . . . [,] external to the people who engage in them" (Collins & Tomm, 2009, p. 110).

Another influence on the theoretical framework of the IPscope was Maturana's concept of *bringforthism* (K. Tomm, personal communication, August 13, 2019). With its grounding in biology, this theory "explains how all living systems know how to survive

through the organization of their component parts, . . . [enabling] the process of living to emerge" (K. Tomm, personal communication, August 13, 2019).

Key to this understanding is the idea of structure determinism, a core assumption of Maturana's theory, which posits that whenever two entities interact, "the response of the other is always determined by their own organization and structure" (K. Tomm, personal communication, August 13, 2019). When we talk, for example, there is "a coupling between what you hear and what I'm saying by virtue of us drifting together in English over a long period of time, but there's never a one to one correspondence between . . . what's being said and what's being heard" (K. Tomm, personal communication, August 13, 2019).

Maturana made the point that teaching is not possible; one cannot put an idea into another's head. This notion relates to the process of therapy as well. However, while therapists cannot put information into clients' heads, they can "create conditions where [clients] can learn potentially" (K. Tomm, personal communication, August 13, 2019). Through structural coupling, we engage in recurrent interactional patterns that are not deterministic, but become stabilized, as "mutual invitations to maintain the recurrency of that coupling of behaviors" (K. Tomm, personal communication, August 13, 2019). Giving "priority to seeing the connection as existing *between the behaviors* in the interpersonal space, and not within either person's character" (Tomm, 2014a, p. 17), is useful for both clients and therapists. It serves as a way "to externalize pathology, to diminish entanglement in shame and blame, and to open space for therapeutic change" (p. 17). As family members engage with one another in patterns of interaction, systemic therapists attend to the interactions between the individuals, as well as to the complex

ways that relationships— including those that each family member has outside the family unit—have on each other.

The IPscope was created in a teaching program "as a perceptual/conceptual instrument to guide students" (Couture & Tomm, 2014, p. 58) in making the shift from seeing problems and their solutions as located within individuals, to "understanding them as relational patterns in the interpersonal space" (p. 58). In designing the IPscope, Tomm was organized by an orienting question: "How can we bring forth aware[ness] of relational dynamics and hold that awareness sufficiently [so] that we can then act on that awareness, to be able to be therapeutic in enabling relational change, that's going to be therapeutic?" (K. Tomm, personal communication, August 13, 2019). Selectively attending to interpersonal patterns can be helpful, primarily because we are entrenched in specific patterns of interaction that have "a major influence on our experiences and on our mental well-being" (Tomm, 2014a, p. 15).

Although we are immersed in interpersonal patterns characterized by ever-changing levels of relational stability, we tend to lack awareness about how they are brought forth, how they are upheld, and how we might alter them when they are not useful. Focusing on interpersonal patterns "helps elucidate the vicissitudes of these experiences" (Tomm, 2014a, p. 15) and simplify that which is otherwise very complex, so we may focus our efforts on facilitating change. Additionally, viewing the problem as "between us, not within us" (Collins & Tomm, 2009, p. 110) allows the problem to be externalized in the therapeutic conversation, a concept Tomm took from Michael White's narrative work.

The *IP* in IPscope refers to *interpersonal patterns*; the suffix *scope* references "human made instruments, which help observers see that which is ordinarily hard for the naked eyes to see, like a microscope or telescope" (K. Tomm, personal communication, August 13, 2019). Putting the prefix and suffix together, IPscope "is a cognitive instrument for distinguishing and describing Interpersonal Patterns (IPs) for systemic assessment" (Tomm, 2014a, p. 18). An analogy used for the IPscope is that of a kaleidoscope, inferring that we are continually in the process of creating different tones among the colors and patterns that shift as therapists co-construct change with families in therapy.

Interpersonal Patterns (IPs) are defined as "repetitive or recurrent interactions between two or more persons distinguished by an observer . . . that highlight the coupling between two classes of behaviors, attitudes, feelings, ideas, or beliefs and that tend to be mutually reinforcing" (Tomm, 2014a, p. 19). Tomm and his colleagues identified six different interpersonal patterns, which are illustrated in Figure 2.

Figure 2
Simple Graphic Diagrams are Used to Describe the Interpersonal Patterns (IPs) That are Distinguished (Tomm, 2019, slide 17)
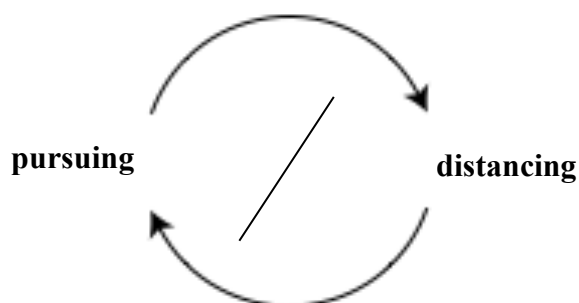
The text used to describe the behaviors in the pattern is in gerund form to indicate that such coupling between certain behaviors occurs in the present. The behaviors are connected by two arching arrows—each arrow inferring a separate invitation—that form a circle. As Tomm explains, "circularity implies recurrency [of a] pattern that emerges again and again" (K. Tomm, personal communication, August 13, 2019). Since behaviors such as distancing and pursuing are not deterministic, the invitational aspect of the connection between those behaviors is critical. This invitation can either be accepted or declined, which presents an opportunity for change to emerge. Seeing the patterns as *invitational couplings* or *mutual invitations* permits individuals to see behaviors they want to alter and identify the possibility of issuing a different sort of invitation to elicit a different response. The slash that connects the two behaviors in the diagram represents reciprocity "and implies the coupling of complementary behaviors" (Tomm, 2014a, p. 19). The pattern is generally drawn horizontally; when drawn vertically, it denotes a power differential, whereby the stronger component of the pattern is reflected above the weaker one.

As we regularly engage in relationships and, accordingly, enact patterns of interaction, we are generally living wellness patterns "out of conscious awareness" (K. Tomm, personal communication, August 13, 2019). A pattern of speaking/listening is an example of a Wellness Interpersonal Pattern (WIP), which Tomm defines "as a recurrent interpersonal interaction that enables generativity, competence, and/or effectiveness in one or both participants and/or that sustains or enhances health in the relationship" (K. Tomm, personal communication, August 13, 2019).

A Pathologizing Interpersonal Pattern (PIP) is "a recurrent interpersonal interaction that invites or increases negativity, pain and/or suffering in one or both persons interacting, or results in significant stress within the relationship" (Tomm, 2014a, pp. 20-21). According to Tomm (1993), PIPs offer a means to create separation between the person and the problem, locating the problem in the pattern instead. Giving each of the behaviors in the coupling a name or label pathologizes the interactional pattern, rather than the individuals enacting the pattern. As a result, "any exclusion practices . . . mobilized by . . . negative labeling are then harnessed as resources in the protest" (p. 69) toward the pattern instead of toward the individuals. A frequently observed PIP, criticizing/defending is particularly common, since both parties can be recruited into it easily, switching seamlessly and frequently from one position to the other. It is important for therapists to recognize that they can easily be recruited into this pattern. As Tomm explains, "the chances of us avoiding slipping into and adding to isomorphic pathologizing patterns is diminished if we're aware of the possibility of issuing a different invitation to healing patterns instead" (K. Tomm, personal communication, August 13, 2019).

A sub-category of PIP, the Deteriorating Interpersonal Pattern (DIP), "creates conditions for a possible or probable slip from a positive pattern (i.e., from a WIP, HIP, or TIP) toward a PIP" (Tomm, 2014a, p. 21). It is significant because it denotes the start of "slippage into a negative process" (K. Tomm, personal communication, August 13, 2019). When caught early, a DIP can be identified and recovered from, and movement toward a wellness pattern can then resume. This can be most useful towards the end of

therapy, presenting an opportunity for families to become aware of their DIPs and develop competence in recovering from them.

One example of a DIP is a person looking at someone with a scrutinizing and critical eye, which leads the scrutinized person to become self-conscious, awkward, and disorganized. Tomm points out that this type of interaction commonly takes place during the traditional psychological assessment, "in which [therapists] inadvertently contribute to distress in . . . patients[,] . . . asking about [their] failures, tragedies . . . [which essentially] re-traumatize[s] them" and leads to "pathologizing dynamics" (K. Tomm, personal communication, August 13, 2019).

A sub-category of wellness patterns (WIP), the Healing Interpersonal Pattern (HIP) "constitutes a specific 'antidote' to a particular PIP by bringing forth positive behaviors and/or experiences (in one or both of the participants) that specifically preclude or contradict some component of the PIP" (Tomm, 2014a, p. 21). A special type of wellness pattern, HIPs differ from WIPS by virtue of "their potential effect in displacing pathologizing patterns" (p. 21). Considered patterns of growth or healing, HIPs may be a challenge to introduce, especially when the PIP is a deeply entrenched interactional pattern in a relationship. Through a process of co-construction therapists can work with clients to shift interactional patterns from PIPs to HIPs (Tomm, 1991). This process serves as "a very powerful healing dynamic in relationship systems" (K. Tomm, personal communication, August 13, 2019). Once the problem is externalized into the interpersonal space, the HIP can be internalized as the problem's antidote. This critical aspect of Tomm's work differs from the work of Michael White, who did not describe the process of internalizing (Collins & Tomm, 2009).

This system of understanding demonstrates that we experience relationships as a series of interactional patterns in a continuous dynamic process. We move away from pathologizing patterns by bringing forth patterns of healing that can become wellness patterns. According to Tomm, the difference between:

> so-called dysfunctional families [and healthy families is that] dysfunctional families tend to live more . . . time in the left hand side of the diagram, . . . in PIPs, they slip into [them], . . . get caught in [them], and . . . struggle in . . . whatever the pathologizing pattern might be, . . . they get stuck, and they stay there. (K. Tomm, personal communication, August 13, 2019)

However, it is important to recognize that pathologizing patterns are not all these families have. As therapists, it is vital for us to attend to families' healing and wellness patterns as well. Although families that are considered healthy may spend most of their time in wellness patterns, they engage in pathologizing patterns as well. However, "they recover from their PIPs quickly . . . so the difference here is a matter of degree. [They are] not qualitatively different systems" (K. Tomm, personal communication, August 13, 2019).

A Transforming Interpersonal Pattern (TIP) is another sub-category of the WIP, "which enables movement from a PIP toward a HIP or WIP" (Tomm, 2014a, p. 21). These kinds of patterns (TIPs) are the ones that therapists engage in during therapy, such as when they invite "people to disclose their concerns, which makes it possible . . . to ask more differentiated questions about their concerns" (K. Tomm, personal communication, August 13, 2019). Engaging in this type of clarifying conversation can be thought of as a TIP, specifically a deconstructive TIP, as it helps "diminish the . . . power and pervasiveness of the pathology coupling" and "invites the other to disclose the relational

nature and origins of problems, which then makes it possible to extend that inquiry" (K. Tomm, personal communication, August 13, 2019). A co-constructed TIP is what happens when the therapist engages the client in a process of asking reflexive questions and opening space for possibilities. In a utilization TIP, the therapist asks about helpful variations in a PIP or recognizes aspects of it that are akin to a HIP. Tomm developed this type of pattern based on the concept of "utilization[,] a concept or a notion that . . . Milton Erikson was well-known for . . . [as he] had a unique talented gift for being able to use the energy in problems and guide that energy to be utilized toward betterments and improvement" (K. Tomm, personal communication, August 13, 2019).

The framework of interactional patterns was extended to include Socio-Cultural Interpersonal Patterns (SCIPs), defined as "social-cultural interactional patterns that describe how family members adopt and enact social discourses, values, and/or beliefs in our culture, [thereby reinforcing] and/or re-inscrib[ing] the discourse or pattern in the community or the culture" (K. Tomm, personal communication, August 13, 2019). Depending on how they are embodied or enacted, these patterns "can either be unhelpful and limiting (PIP) or helpful and healthful (HIP)" (St. George & Wulff, 2014, p. 132). Although generally outside our conscious awareness, SCIPs are always occurring, and, as such, tend to support patterns of wellness or pathology, justifying the importance of inquiring about them in our work with families.

The IPscope was developed, in part, as another way of conceptualizing family systems in contrast to the DSM and its effects on clients. As previously discussed, all our mental experiences—including thoughts, actions, emotions, and intentions—theoretically emerge through social interaction. This concept was espoused by both Bateson and

Maturana, who claimed that "the human Mind is first and foremost social, and secondarily psychological" (K. Tomm, personal communication, August 13, 2019). Although we tend to conceptualize the Mind as separate, "our experience of a separate mind is an illusion" (K. Tomm, personal communication, August 13, 2019). Language, for example, does not reside inside the brain; rather, it is around us. It can be said that we are in language; and that language evolves from our social interactions. Tomm posits that if all we experience mentally arises in the social domain, then it should be credible to "deconstruct an individual 'mental illness' into specific patterns of social interaction" (K. Tomm, personal communication, August 13, 2019). Through his collaborative efforts with colleagues to identify hundreds of PIPs, Tomm (2014a) differentiated certain patterns "that appeared to generate or aggravate particular individual mental problems" (p. 31) and that illuminated their healing antidotes (HIPs).

An example of a pathologizing pattern as it relates to addressing the symptoms of depression might be "*dominating with oppressive practices coupled with submitting with depressive practices*" (Tomm, 2014a, p. 31, italics in the original), with a corresponding HIP of "*acknowledging and relinquishing oppressive practices coupled with protesting oppression and assuming more personal agency*" (p. 131, italics in the original). Another "depressogenic" PIP might be "blaming and diminishing the other, which invites the other to blame and diminish themselves" (K. Tomm, personal communication, August 13, 2019). A corresponding HIP could be "affirming and crediting the other[, which invites] affirming and crediting the self" (K. Tomm, personal communication, August 13, 2019). Other mental problems deconstructed into PIPs and HIPs include psychotic symptoms, lying and stealing, paranoia, sibling rivalry, and adolescent rebelliousness.

Even though the previous examples illustrate a single problematic pattern, there are often "two or three core pathologizing patterns that are seen in families [that mutually reinforce one another] and flip from one to the other very quickly" (K. Tomm, personal communication, August 13, 2019). Tomm explains that this "requires a lot of disentangling . . . to tease them out, and co-constructing awareness of that is part of the therapeutic process" (K. Tomm, personal communication, August 13, 2019). In therapy, the first step in constructing a PIP or becoming aware of one is to "intuit the strongest negative emotions that seem to be active within the main participants of the interaction [, focusing on] what is the most intense negative emotion" (K. Tomm, personal communication, August 13, 2019). Once the therapist has identified the PIP, he or she then looks at the behaviors that express the emotions, choosing those that bring out heightened emotional reactivity.

As therapists observe reactive behaviors, they seek certain complementary behaviors that bolster the reactive ones in a "mutually reinforcing" way (Couture & Tomm, 2014, p. 67), until this pattern presents itself clearly. Describing his own process, Tomm explains:

> I almost hallucinate it, it's a proactive hallucination. . . . If I can see the pattern happening out there in that relational space . . . [, then I can] dissolve their separate individual skin-bounded separateness, [and] I can now bring forth this pattern. (K. Tomm, personal communication, August 13, 2019)

The clearer the pattern is to the therapist, the more easily it can be addressed therapeutically. The problem, or PIP, is externalized to the interpersonal space, but is an intra-personal problem as well, "by virtue of the history of their relationship, . . . [so,

there is also] an internal process going on within them" (K. Tomm, personal

communication, August 13, 2019). This pattern then becomes stabilized at both the

interpersonal and intrapersonal levels. I will elaborate on this idea in future chapters,

within my discussion of internalized other interviewing.

Once a therapist chooses a PIP to focus on, the next step in the process of using

the IPscope is to counter, displace, or generate an *antidote* to it by identifying a

corresponding healing pattern (HIP). The therapist is trained to seek out HIPs—regarded

as pre-existing competencies within a family's repertoire—by paying attention to

"positive transactions" (Couture & Tomm, 2014, p. 68) occurring spontaneously between

family members in session, or to behaviors that could be construed or reframed as

positive. As with PIPs, circular questions can be asked to assist in formulating HIPs. If

there are no observable HIPs, the therapist is encouraged to envisage a behavior distinct

from the behaviors seen in the PIP that could possibly serve "as an 'antidote' by . . .

precluding the performance of the PIPish behavior" (p. 68). Once imagined, the therapist

locates a behavior that is complementary to this one, which can be coupled, and then

"stabilize it as a recurrent preferred behavior" (p. 69). The therapist chooses behaviors

that mutually reinforce one another, so they can "become coupled in the interpersonal

space to stabilize a preferred interaction pattern" (K. Tomm, personal communication,

August 13, 2019). The therapist then draws on those behaviors to further solidify the

pattern.

To more thoroughly understand the IPscope, a number of important aspects,

concerns, and limitations must be considered. Tomm (2014b) notes:

The potential dangers of an over-reliance on the IPscope are restrained by two major phenomena: (a) the difficult stretch entailed in expanding our minds to actually think systemically and (b) the power and pervasiveness of individualistic habits of thought and practice. (p. 230)

Although the process of diagramming interactional patterns simplifies that which is much more complex, care must be taken to avoid incorrectly viewing the diagrams as "first-order descriptions of objective realities" (Tomm, 2014a, p. 33), which could "sustain a drift toward objective 'truth'" (K. Tomm, personal communication, August 13, 2019). As observers of systems, therapists distinguish certain recurring behaviors, couple those behaviors, and then apply them to a two-dimensional drawing to focus our attention. Tomm (2014a) explains that "the therapist-as-participant-observer" (p. 33) creates and labels patterns to orient the therapy process. He points out that being continuously mindful of "'looking at our looking to see what we are seeing, and see how our seeing guides our therapeutic initiatives'" (p. 33), can be difficult. However, the IPscope was intended to be used with this second-order perspective in mind.

Another feature of interpersonal patterns is that what we observe does not exist physically, but only in the imaginations of the observers. It is important to remember that patterns are "cognitive constructions [or] 'serviceable fictions' that . . . are not necessarily objective or real" (K. Tomm, personal communication, August 13, 2019). Even though these patterns can be diagrammed, we must keep in mind that they are "not physical concrete realities; they are conceptual realities" (K. Tomm, personal communication, August 13, 2019).

Tomm cautions about "limit[ing] the possibility of excessive exuberance in an observer's imagination" (K. Tomm, personal communication, August 13, 2019), referring to therapists' tendency to propose healing patterns that might be beyond a family's capacity at the time of therapy. Therapists need to be grounded in what is possible. Being overly enthusiastic could limit their ability to consider alternative ways of describing what they are seeing. Tomm likens this to "the 'Law of the Instrument', like when you discover a hammer, everything looks like a nail" (K. Tomm, personal communication, August 13, 2019). Therapists might have a proclivity to use the IPscope like a cookbook, following it in a formulaic way, and attempting to identify specific patterns instead of aiming to construct what might be unique to a family's interpersonal pattern.

Another limitation of the IPscope is that "it assumes 'normal' biological functioning of the participants and overlooks limitations in the neuroplasticity of interacting brains" (K. Tomm, personal communication, August 13, 2019). If a participant does not have a well-functioning nervous system, it becomes difficult to work with the coupling process. When this is the case, the work can be extended to include another family member in the process. In a similar vein, some therapists might find that working with and conceptualizing patterns is "too abstract and too intellectual[, whereas] others [might find it] too behavioral" (K. Tomm, personal communication, August 13, 2019). In this process, clients and their needs remain the top priority; therefore, deciding to use the IPscope—or any other means of assessment and intervention—is a choice made by the therapist that must be both intentional and ethical.

An important conceptual skill that helps therapists distinguish interpersonal patterns is that of collapsing time in order to render the circularity of a pattern more

visible. Another way to see these relational patterns, perhaps one that is "more 'empirically grounded'[,] is . . . that the patterns are really spirals . . . which if you then collapse [them], you can see the circularity before [you]" (K. Tomm, personal communication, August 13, 2019). Sometimes a therapist can see the coupling of behaviors clearly; other times, it may not show up in the therapy session and only become visible at a later time. Therefore, developing this skill is vital to therapists' ability to understand the continuity of the systemic process.

The same skill can be used therapeutically. When therapists observe an escalating pathologizing pattern, they can ask the clients what they imagine will result if they continue it over a particular period of time. For example, "If this pattern continues, what do you imagine things might be like in six months?" (K. Tomm, personal communication, August 13, 2019). This "collapsing time kind of question" serves as an invitation for clients to look at their escalating pattern and project it into the future, which "makes it possible for [them] to draw the distinction of the direction of evolution of things getting worse" (K. Tomm, personal communication, August 13, 2019).

> According to Tomm, the phenomenon of collapsing time is:
>
> very significant in living systems, because living systems accommodate to their environment. . . . One of the aspects of living is to . . . keep on adjusting with respect to the context of the niche in which the system is living. (K. Tomm, personal communication, August 13, 2019)

By collapsing time, therapists can:

> invite [clients] to recognize the distinction of the direction being problematic, and then [they] are more ready to act. So it's a way to sometimes build a fire under

family members who need to be mobilized into action when they're not yet ready to take action. (K. Tomm, personal communication, August 13, 2019)

One important conceptual skill involves externalizing the behaviors from the persons enacting them, thereby locating the coupling behaviors in the interpersonal space. Recognizing the repetitive and customary nature of interpersonal patterns is another important skill. As Tomm explains:

> Sequences of interaction are stored in memory, which render them 'familiar' . . . , [and] predispose the persons involved to re-enact that pattern, regardless whether the pattern is conscious or not, desirable or not[, knowing] these relational patterns have a profound history. (K. Tomm, personal communication, August 13, 2019)

Rather than pay attention to the patterns they enact, people more frequently focus on the meaning of certain behaviors, whether their own or someone else's. To start interrupting troubling behavior patterns, people can start by recognizing behaviors as patterns and gaining an awareness of how absorbed they are in the process of enacting them (Tomm, 1991).

Generally speaking, it is undesirable for us, as living systems, to participate in pathologizing or deteriorating patterns, since we have a natural, unconsciously driven tendency to move toward wellness. While we might be aware of certain aspects of a problem, we are usually unaware of it in its full scope or circular nature. The act of drawing a complete IPscopic Reflectogram, including the many types of interpersonal patterns, requires deliberate conscious reflection on systemic processes. This assessment method can guide the therapy process, giving therapists a way to understand what is

unfolding in the family system, and helping them identify and organize patterns in ways that can guide the therapeutic process. Therapists conducting the IPscope do not do so from an expert position. Rather, they incorporate the family in the process of identifying the pathologizing patterns, labeling them, and mapping them out, so that they become a valuable learning tool for enabling therapeutic change. Tomm considers the co-constructive process of labeling patterns with clients to be "a very useful therapeutic initiative [that involves] inviting people into consciousness as a resource for themselves to escape pathologizing patterns that they slip into" (personal communication, August 13, 2019).

Feminist family therapists who have critiqued systems theory, deeming it "unsuitable as a foundation for family therapy" (K. Tomm, personal communication, August 13, 2019), could level similar claims about the use of the IPscope. Because the interpersonal interactions are conceptualized in a circular fashion, there is the implication of "equal influence and responsibility of the participants in generating and maintaining problematic patterns of interaction (K. Tomm, personal communication, August 13, 2019). This can "obscure real differences in power between males and females that perpetuates conditions for the gender injustices that arise from such power differentials" (K. Tomm, personal communication, August 13, 2019). To account for this, therapists can use the circularity and recursiveness of the interactional interpersonal patterns as a way to explain what happens in relationships, which can "support . . . [the] assumption of equal power and inadvertently foster continuing gender injustices" (K. Tomm, personal communication, August 13, 2019).

The act "of clinicians assessing mental problems is . . . a culturally determined pattern of interaction which could have either pathologizing or healing effects" (Tomm, 1991, p. 24). In response to this, Tomm (1991) developed the IPscope to shift the focus from "the personal to the interpersonal" (p. 24), offering a way to distinguish and label *patterns*, and not clients, as pathological. For Tomm, this method served to embody his hope for a form of assessment and admission criteria that could guide his family therapy program. As he explains, "the HIPs and PIPs 'means' to assessment does not contradict the 'ends' of the program, it contributes to them" (p. 24).

In practice, Tomm (2014b) "personally oscillate[s] between proposing the IPscope as an alternative to the . . . (DSM) . . . , as opposed to a healing complement to" it (p. 232) . He has found that his discussions with psychiatrist colleagues are more productive when he presents "descriptions of PIPs as *complementary* to individual mental disorders" (p. 232). This both/and perspective supports the idea that:

> as lived events unfold over time, pervasive relational patterns can be seen to transform into individual phenomena, as end results or distillates. Ongoing PIPs can end up presenting as individual problems, and likewise, longstanding WIPs can end up becoming positive individual traits. (p. 232)

Although some may have concerns about the stigmatizing or oppressing effect of using the term *pathologizing* to describe behavior patterns, Tomm explains that he transferred the term "from [his] medical heritage into [his] professional training" (K. Tomm, personal communication, August 13, 2019). He finds the "adversiveness of the pathologizing implications useful, . . . as a potential resource, as a way of mobilizing the energy of [clients'] emotional aversion to that, to want to get away from it" (K. Tomm,

personal communication, August 13, 2019). However, he acknowledged that other labels, such as *problematic,* can be used instead (K. Tomm, personal communication, August 13, 2019).

What sets Tomm apart from other theorists who identified patterns of interaction and "facilitated therapeutic change at the relational level" (Strong et al., 2008, p. 176)—including Bowen, Johnson, and Minuchin—is "his *collaborative* approach to identifying PIPs and developing HIPs" (p. 176). Guided by theory and incorporating families' own understandings, he has provided observations that family members might find useful. His approach offers a way of working with clients to arrive at what they find most meaningful.

Interventive Interviewing

Tomm wrote a series of articles on the use of questions in therapeutic interviews that incorporated his circular interviewing work, built upon his experiences with the Milan team, and integrated ideas borrowed from Maturana and Bateson. Distinguishing ordinary conversations from those that are therapeutic, Tomm (1988)'s articles describe the therapeutic conversations transpiring between a therapist and client "within the context of consensual agreement" (p. 1), explaining that they are constructed in such a way as to alleviate "mental pain and suffering and to produce healing" (p. 1). He emphasizes the special role that therapists assume in their commitment to help those who are suffering, explaining that while there are certain responsibilities inherent in this position, "it also confers special privileges" (p. 1).

Captivated by the wide range of effects a therapist has on a client in a clinical interview, Tomm (1987a) notes that in a typical session, therapists most often ask

questions "designed to help him or her formulate an assessment" (p. 3). He notes, however, that many of these questions have a direct therapeutic effect on clients, as well as an indirect effect that comes by way of their responses to the questions, which can also "be countertherapeutic" (p. 3). Strong et al. (2008) assert that the series of articles represents Tomm's "most influential writing" (Strong et al., 2008, p. 175), as it lays out the "ethical and constructive implications" of therapeutic interviews, and "reconceptualize[s] *all* counsellor interactions with clients as potentially interventive" (p. 175). Emphasizing this point in his articles, Tomm (1987a) asserts that it is not possible "for a therapist to interact with a client without intervening in the client's autonomous activity . . . [, and] no statement or nonverbal behavior is assumed, a priori, to be inconsequential. Nor is the absence of certain actions considered trivial" (p. 4). Providing the foundation for what he refers to as an *interventive interviewing* process, he describes it as "an orientation in which everything an interviewer does and says, and does not do and does not say, is thought of as an intervention that could be therapeutic, nontherapeutic, or counter-therapeutic" (p. 4).

Tomm developed what is known as the *original* framework for interventive interviewing, which he still incorporates in his clinical practice. More recently, he collaborated with Carsten Hornstrup, an organizational consultant, to develop a *revised and expanded* version, which was published in the Danish language in 2009 by Hornstrup, Tomm, and Johansen, but has not yet been published in English (K. Tomm, personal communication, August 14, 2019). Both Tomm and Hornstrup agree that the original framework is more useful for those therapists:

who are in the process of moving into the social constructionist bringforthist

paradigm, away from an empirical [one] . . . because it does enable that shift in

terms of moving into the view of multiple truths, multiple realities, and then being

able to choose among those realities. (K Tomm, personal communication, August

13, 2019)

The revised framework, on the other hand, is more useful for therapists who are already

ensconced in these ways of thinking and practicing, as it builds upon already existing

knowledge, enhancing and broadening what is possible. Therapists who use the new

framework are invited to notice the continued effects of their interventions, to ask

themselves if what they are choosing is useful or, perhaps, problematic, and to focus not

only on the client system, but on their own behaviors as a part of that system.

Interventive interviewing calls upon therapists to be continuously intentional

about the questions they ask, remaining aware of the equivalence between their intended

and actual effects. Rather than focusing on the interventions they use in session,

therapists who use the interventive interviewing approach remain focused, instead, on *all*

their actions. When they notice a gap between their intended and actual effects, they can

diminish it by developing more refined skills that align with their intentions. Tomm

points out that there may be times when family members' responses to a question are

disconnected from the actual question the therapist asked. This, he points out, is "an

absolute limitation . . . , as the listening and responses of clients are always determined by

their own biological autonomy [and is] depend[ent] on the uniqueness of [the family's]

own organization and structure at each moment" (Tomm, 1988, pp. 6-7). Therapists can

improve the connection between the intended and actual effects of their questions by

"enhancing [their] linguistic coupling with clients through the conceptual posture of circularity" (p. 7).

To minimize the complexity of this approach and provide guidance for therapists, Tomm developed a fourth guideline for interviewing, built upon the first three—hypothesizing, circularity, and neutrality—developed by the Milan team. The guideline of strategizing, intended to help guide the therapist's decision-making process, is defined as, "the therapist's (or team's) cognitive activity in evaluating the effects of past actions, constructing new plans of action, anticipating the possible consequences of various alternatives, and deciding how to proceed at any particular moment in order to maximize therapeutic utility" (Tomm, 1987a, p. 6). This guideline enables therapists to be more intentional about the choices they make as they commit themselves to working toward a therapeutic goal.

In an effort to inspire therapists to take more responsibility for the choices they make, Tomm (1987a) describes the guidelines as conceptual postures, or "enduring constellation[s] of cognitive operations that maintain a stable point of reference which supports a particular pattern of thoughts and actions and implicitly inhibits or precludes others" (p. 7). Therapists assume conceptual postures with conscious awareness when they are first learning them. However, as the learning deepens, the posture then becomes a "part of the therapist's nonconscious flow of activity" (p. 7).

Tomm conceptualized a posture of circular hypothesizing, which involves asking circular questions that generate greater therapeutic possibilities and orient toward more systemic explanations. His intention was to reformulate the Milan team's guideline of hypothesizing and clarify the group's original description, which "led to considerable

confusion" (Tomm, 1987a, p. 7). According to Tomm, this confusion resulted from the lack of a clear distinction between the circularity of the observed and observing systems, or rather, the different domains of first- and second-order cybernetics. Lineality, as described by Bateson (2002), is "a relation among a series of causes or arguments such that the sequence does not come back to the starting point . . . [and] the opposite of lineal is *recursive*" (p. 212). Thus, Tomm (1987a) came to see the posture of circularity as one encompassing the recursiveness of the observing system, a process that emphasizes the "dynamic structural coupling between the therapist and the family" (p. 8) as they move together as an evolving system. The therapist continually moves in relationship with the family's movement. This notion, which aligns with Maturana's theoretical ideas, abandons the use of "functional hypothesizing" (Collins & Tomm, 2009, p. 112).

Regarding the guideline of neutrality, Tomm (1987a) explains that "it is physically and logically impossible to remain absolutely neutral" (p. 8). Therefore, it is important for therapists to understand what it means to adopt this conceptual posture in their systemic clinical work. In a clinical interview, "the therapist accepts everything as it is taking place in the present, and avoids any attraction to, or repulsion from, anything that the client(s) says or does" (p. 9). As they stay open to whatever transpires, therapists must attend to their own assumptions about the situation or the clients, so that they can avoid being drawn into assuming one position or another. Staying tentative about their perceptions allows them to become more flexible with their intentions, leaving "more space for the intuitive, nonconscious aspects of cognition to emerge and become active in the therapeutic process" (p. 9). From a social constructionist and bringforthist

perspective, therapists place "objectivity in parenthesis" (p. 9), not professing to know what is true or "what is useful or not useful" (p. 9).

Although neutrality and strategizing appear to be contrasting postures, "neutrality is founded on an acceptance of 'what is' [while] strategizing is based on a commitment to 'what ought to be' (Tomm, 1987a, p. 10). Assuming too much of a particular posture has a direct impact on what is possible in therapy. Being too ensconced in neutrality, accepting all that is, can limit a therapist's potential to make therapy useful. Heeding Bateson's warning about "the inherent blindness and lack of wisdom in too much purpose" (p. 10) and excessive strategizing, Tomm proposes a posture that can serve as "a strategic commitment to neutrality" (p. 10).

The concept of strategizing, which serves as a basis for interventive interviewing, also encompasses therapists' commitment to assume full responsibility for their choices and behaviors—or, in other words, to strategize about their strategizing (Tomm, 1987a). Through self-examination and supervision, therapists can critically assess the postures they assume, to determine their tendencies and decide to make changes in certain areas. As therapists attend to the four conceptual postures, they must take care to apply them in a recursive way. Attuning themselves to the nuances in the therapeutic system affords them a heightened sensitivity to the effect of one posture or another. This enables them to recognize if they are creating constraints by strategizing too much or stagnating the process by strategizing too little. As Tomm (1987a) explains, knowing how to assume and modify the conceptual postures will eventually "'sink' into nonconscious process . . . so that the therapist's consciousness can "float" freely to where it is most needed to maximize the clinical effectiveness of the interview" (p. 13).

As clients share their experiences and emotions, therapists communicate through language, using a combination of questions and statements to further elicit a healing conversation. Statements are generated by and focused on the person speaking, as they "*set forth* issues, positions, or views" (Tomm, 1988, p. 1); questions, on the other hand, "shift to focus on [the client's] experience, [the client's] views" (K. Tomm, personal communication, August 14, 2019), which serves to "*call forth* issues, positions, or views" (Tomm, 1988, p. 1). Questions steer the focus of the interview toward the clients, their situations, and their lived experiences, inviting them "to become engaged in the conversation" (p. 1). However, Tomm (1988) points out that therapists may have a tendency to "hide behind the perpetual questions" (p. 2), thereby diminishing the potential for establishing a therapeutic alliance. For clients to feel a sense of trust, they must hear statements as well. Since questions can contain statements, and statements can contain questions, therapists should be mindful about how they incorporate both within the interview. For example, they may intentionally choose to make more statements that embed questions when meeting with clients who are sensitive about being questioned due to their age, cultural background, or family history.

Because questions can be used to change meanings or understandings and construct new ideas, therapists engaging in the interview process hold immense power. Furthermore, due to the cultural expectation that questions must be answered, therapists' questions invite certain categories of responses. As Tomm points out, therapists "implicitly define the domain of a legitimate answer" (K. Tomm, personal communication, August 14, 2019). Depending on how therapists employ them, questions can have a range of effects, from "intimidating and [being] oppressive, . . . [to] affirming

[and being] supportive and enabling" (K. Tomm, personal communication, August 14, 2019). When incorporated intentionally, questions can inspire clients to work through their problems, "foster[ing] . . . autonomy and allow[ing] a greater sense of personal achievement . . . rather than inducing dependency on the 'special knowledge' of the therapist" (Tomm, 1988, p. 1).

The concept of interventive interviewing was inspired by research Tomm conducted on his own interviews with families, in which he "drew distinctions, looked for sequences, and for commonalities" (K. Tomm, personal communication, August 14, 2019). This informed his idea that "every question may be assumed to embody some intent . . . [, which] arises from the conceptual posture of strategizing that guides the therapist's moment-to-moment decision making during the conversation" (Tomm, 1988, p. 2). What he discovered was that all questions can be organized into two dimensions. He discovered that all questions, which can be thought of as a form of intervention in the therapeutic process, can be classified in two ways: by the therapist's *intention*—which is either orienting or influencing—and by the therapist's *assumptions* regarding the process of interaction—which is either lineal or circular (K. Tomm, personal communication, August 14, 2019).

According to Tomm (1988), the "primary locus for intended change" (p. 2) when asking orienting questions is the therapist, while the locus of change with influencing questions is the client. Therefore, therapists typically use orienting questions earlier in the interview. Tomm explains that he prefers to use mostly influencing questions, as it makes him "less likely to ask a question that is going to have an inadvertent harmful negative effect" (K. Tomm, personal communication, August 13, 2019). Tomm's understandings

about the use of questions was influenced by Bateson's work, which helped him see how lineal thinking and causality decrease our ability to comprehend mental processes (Tomm, 1988).

Just as the assumptions we hold influence how we conceptualize and perceive our world, they also inform the questions we ask. From a lineal perspective, time runs in a straight line from past to present to future. Those who adhere to this assumption will ask questions that reflect a lineal sense of time. Alternatively, those who are oriented toward circular assumptions will ask time-related questions that bring experiences from the past and anticipated future into the present. The circular perspective shapes questions that invite new understandings about the circular nature of interactions and relationships (K. Tomm, personal communication, August 14, 2019).

Lineal questions and circular questions are both rooted in an orienting intention; however, the assumptions behind them are not the same. While strategic and reflexive questions are both used when a therapist intends to be influencing, strategic questions—which are based on lineal assumptions—are used when a therapist is "trying to push the person into what they believe is better for them in the future" (K. Tomm, personal communication, August 14, 2019). Reflexive questions—used with an influencing intention but grounded in circular assumptions—can be "seen as a perturbation in the . . . therapeutic system and process of interaction" (K. Tomm, personal communication, August 14, 2019). To explain why he uses such questions, Tomm states: "because I want to be up front; I want change . . . I'm on the side of therapeutic change. I'm not neutral about change" (Bubenzer et al., 1997, p. 90).

Different types of questions elicit different effects. A therapist seeking to define, explain, or further develop the problem would most likely ask a *lineal* question. They would use a *circular* question if the intention was to understand the effect of a behavior or inquire about difference. Leading or confrontation questions "tend to be regulatory" (Tomm, 1988, p. 4) and are generally *strategic* questions. To inquire about an observed perspective or a hypothetical future, a therapist would generally ask *reflexive* questions (K. Tomm, personal communication, August 14, 2019; Tomm, 1988).

According to Tomm, "the semantic content and linguistic structure of the question does not determine its type; it is determined by the intentionality of the interviewer in asking in this particular context at this moment" (K. Tomm, personal communication, August 14, 2019). When asking a lineal question, the therapist assumes the position of an investigator, whose intent "is to generate a cause and effect understanding . . . to clarify [a] sequence of events over time" (K. Tomm, personal communication, August 14, 2019). The therapist assumes "a reductionistic stance in trying to determine the specific cause of the problem" (Tomm, 1988, p. 4). One potential risk associated with asking lineal questions is that clients may unknowingly step more deeply into their pre-established story, "embed[ding] the family even more deeply in lineal perceptions" (p. 7) and inadvertently working against opening space for change. At times, clients feel they want and need to be listened to; lineal questions can provide this sense of validation for their experience. However, these questions also have the potential to leave the client feeling judged.

Through circular questioning, the therapist aims to "become 'coupled' with the family" (Tomm, 1985, p. 34) in a process of exploring and opening space for growth. In

this way, circular questioning becomes "a *systemic enactment* in the" (p. 34) therapeutic relationship from the position of not knowing and discovery. In the cybernetics of observed systems, the therapist observes for the purpose of empirically identifying circular connections in the family system. In contrast, the therapist oriented by second-order cybernetics asks circular questions to *bring forth* or *collaboratively construct* entities.

Tomm (1985) emphasizes that the second-order position is difficult to maintain, due to "our day-to-day conceptual habits . . . , [which are] predominantly objective and empirical. . . . We are faced with a constant covert 'drag' towards a first order cybernetic stance" (p. 35). As Bateson (2002) explains, "very few persons . . . doubt the objectivity of such sense data . . . or their visual images of the external world. Our civilization is deeply based on this illusion" (p. 29). Thus, the systemic therapist is tasked with maintaining a second-order cybernetic stance while trying to simultaneously comprehend the system and foster change. This process is enhanced using two types of circular questions: descriptive and reflexive. When attempting to further understand the relational aspects of a client's problem, a therapist can ask a descriptive question. To generate a change in the client and system, a reflexive question will be most appropriate.

Circular questions are predicated on the assumption that "the organisation of any system is necessarily circular . . . [and] is always a *composite* unity" (Tomm, 1985, p. 37). As a whole made up of parts, a system "is the *coherent* organisation of the components [that] depends on reciprocal or recursive . . . relationships between the components" (p. 37). For the systemically informed therapist, what is most relevant is

how the client's relationships, feelings, behaviors, and beliefs connect in a circular fashion.

When asking circular questions, the therapist's intention is to deepen understanding about the relational context of events and behaviors, as well as the patterns of interaction in the present. The therapist approaches these questions in an exploratory way, "to determine the connectedness of different phenomena . . . [so as] to co-construct a contextual understanding" (K. Tomm, personal communication, August 14, 2019). This understanding is not only significant for the interviewer, but for the client as well. The intent is "to bring forth the 'patterns that connect' persons, objects, actions, perceptions, ideas, feelings, events, beliefs, contexts, and so on, in recurrent or cybernetic circuits" (Tomm, 1988, p. 5). Unlike lineal questions, which can leave clients feeling judged, circular questions are more likely "to activate an accepting effect on both interviewer and client . . . as people come to see how they're embedded in these relational processes and dynamics" (K. Tomm, personal communication, August 14, 2019). This developing awareness supports the idea of behaviors making sense in context, as clients see the interrelationships in their interactional patterns.

Through circular questioning, clients may "get liberated from their lineal views" (K. Tomm, personal communication, August 14, 2019). However, "as the therapist explores larger and larger areas of interaction, the inquiry may drift into domains that seem irrelevant to the immediate concerns . . . of the family" (Tomm, 1988, p. 7). Therapists new to this type of questioning may tend to structure and ask circular questions in a prescribed way; therefore, they must be careful about keeping the questions

relevant to the context of the conversation and client. All implications considered, circular questions are more likely to yield useful effects than lineal questions.

The intent of asking strategic questions is to influence clients in a specific direction that the therapist determines is best for the client. Since these questions "tend to be directive and impositional" (K. Tomm, personal communication, August 14, 2019), the therapist asking them assumes the stance of teacher, implying that "instructive interaction is possible" (Tomm, 1988, p. 5). Accordingly, clients may feel compelled "*not to do* something that the therapist thinks is 'wrong' . . . or *to do only* what the therapist thinks is 'right'" (p. 7).

Although strategic questions can have a manipulative and controlling effect, they can also "be extremely constructive . . . [especially when] used to challenge problematic patterns of thought and behavior" (Tomm, 1988, p. 8). Clients may react in oppositional ways to the effects of this type of question, which can cause tension in the interview process. Tomm sees this as an opportunity for the therapists to reflect on the effects of the questions they ask and consider how their clients might be experiencing them. By doing so, they can learn how they have been contributing to the opposition, alter the types of questions they ask to help mitigate the struggle, and change the direction of the interview (K. Tomm personal communication, August 14, 2019).

The fourth type of question, the reflexive question, "tends to be much more respectful and enabling" (K. Tomm, personal communication, August 14, 2019). Asked with the intention "to invite constructive change[, it serves] . . . as a perturbation in the circularity of the therapeutic system . . . to open space for alternative meanings" (K. Tomm, personal communication, August 14, 2019). These questions:

have a generative effect on the clients because . . . if the questions are meaningful

. . . , and influence the client into domains of possibility that they previously . . .

didn't have access to, . . . then they generate possibilities in their own awareness.

(K. Tomm, personal communication, August 14, 2019)

Although the intention of asking both reflexive and strategic questions is to influence clients in a certain direction, asking reflexive questions is considered "a more neutral mode of inquiry . . . because it is more respectful of the family's autonomy" (Tomm, 1988, p. 6). A potential issue associated with using this type of question is that "it could foster disorganizing uncertainty and confusion[;] . . . however, [this] may not . . . be problematic . . . [and] may, in fact, be very therapeutic" (p. 8). Tomm points out that in general, asking reflexive questions also has a "creative effect" on the therapist (K. Tomm, personal communication, August 14, 2019).

When therapists ask questions, they can never be certain how it will impact their clients, as the "actual effects always remain unpredictable" (Tomm, 1988, p. 8). Often, the effects are unobservable during the interview and continue to be even weeks or months later. However, some questions "linger in the minds of clients . . . and continue to have an effect" (p. 9). As Tomm sees it, this unpredictability is a reason for therapists to be mindful of their actions and "take responsibility for the questions being asked without ever knowing what their full effects might be" (p. 9).

What therapists can do is commit themselves to "personal professional development" (Tomm, 1988, p. 9), which can increase the likelihood that their work will be therapeutic. Tomm offers the following advice for therapists who notice that the

direction of the interview starts feeling constrained or heading in a non-therapeutic direction:

> Abandon the framework [and] go with your intuitive knowledge, [which is] larger
> than your conscious knowledge . . . [,] reflect[, and] over time, you . . . [will]
> become more . . . able to engage in . . . interventive interviewing and be mindful
> of the initiatives you're taking . . . [,] the questions you're asking[,] and the effects
> of those questions. (K. Tomm, personal communication, August 14, 2019)

The process of assessing interpersonal patterns and conceptualizing the therapeutic interview as interventive, such that questions are used intentionally and ethically, provides a solid foundation for effective therapy sessions.

CHAPTER VI: FROM DE-CONSTRUCTION TO CO-CONSTRUCTION

I think if one can develop a forgiveness lifestyle, I think that one is in a

position of more readiness with respect to dealing with injustices that

occur.

—*Karl Tomm* (personal communication, August 14, 2019)

Tomm's approach to understanding and working with the problems families bring

to therapy entails a process that begins with de-construction and, as this chapter

describes, moves to co-construction.

De-Constructing Shame and Guilt

Referenced earlier and expanded upon here, the process of disentangling,

deconstructing, and distinguishing between shame and guilt is a significant aspect of

Tomm's clinical work, as well as an important precursor to the process of co-constructing

new possibilities. When we consider the emotions of shame and guilt, we generally tend

to categorize them as problematic. However, in certain circumstances, they can be quite

useful. Guilt, or "anticipatory guilt, is useful in terms of . . . making choices to be

respectful in relation to each other . . . [, whereas] shame is useful in terms of maintaining

boundaries . . . and social relationships" (K. Tomm, personal communication, August 15,

2019).

However, *toxic* shame and guilt, which are experienced as unsettling emotions

that frequently prevent movement in the direction of apology and forgiveness, interfere

with the process of moving toward patterns of wellness. When strong negative feelings

are directed toward oneself, such as feeling guilty about an adverse action, one's identity

can become the target of "self-loathing . . . and become transformed into pervasive

shame" (Tomm, 2002, p. 69). As these negative and disparaging thoughts about oneself escalate, the effect can be both "debilitating and paralysing" (p. 69). Thus, "living in the grip of tangles of shame and guilt is extremely oppressive and can arouse temptations of relief through suicide" (p. 69). Assisting clients to untangle and redefine these emotions can be useful.

Despite being frequently used interchangeably, shame and guilt are significantly different emotional phenomena, as are the processes of deconstructing them. Shame, related more to "one's identity and sense of self" (Tomm, 2002, p. 69), originates outside the self and can be thought of as "an identity wound" (K. Tomm, personal communication, August 15, 2019). It may occur directly, from others participating in shaming practices, or indirectly, from "judgemental cultural beliefs and values that have been imposed or are passively internalised" (Tomm, 2002, p. 69). To help loosen shame's grip, the therapist initially identifies and acknowledges feelings of shame and then seeks to understand their origins. It is useful for clients to recognize "the injustice of such shaming" and to discover their "own acts of resistance against this injustice" (p. 69).

Through protest, the process of challenging shaming practices, which originate from judgmental cultural beliefs and values, can commence. Clients can start "honouring themselves for resisting such oppression [and begin to replace the shame with] self-respect and self-appreciation" (Tomm, 2002, p. 69). Emphasizing the importance of this process, Tomm states, "If you honor the self [for] resisting injustice, [you assume] a position of greater safety to mobilize the anger and rage with respect to the injustice" (K. Tomm, personal communication, August 15, 2019). However, mobilizing anger and rage

prematurely can increase the risk of "self-harm and suicide" (K. Tomm, personal communication, August 15, 2019).

Expressing anger is essential to the deconstruction process, since it is the emotion that displaces shame. Utilizing anger as a way to outwardly protest injustice enables one to use "resentment to hold offenders accountable, contributing to conditions for an apology . . . [, thereby] relinquishing resentment through circumscribed forgiveness" (K. Tomm, personal communication, August 15, 2019). However, if anger occurs "when there's not enough sense of self-worth, [it] can be directed at the self rather than . . . against the injustice" (K. Tomm, personal communication, August 15, 2019). Thus, care must be taken to elicit an active resistance against the shaming practices and to ensure that the person "believe[s he or she] deserve[s] better" (K. Tomm, personal communication, August 15, 2019).

Guilt is most often connected to certain "behaviours, whether they are acts of commission or of omission" (Tomm, 2002, p. 69). Emerging from an internal source, guilt frequently arises from realizing one has injured another, or from reflecting upon one's hurtful acts of omission that have negatively impacted others. In deconstructing guilt, one must accept responsibility for and acknowledge wrongdoing. Restoring the relationship involves taking responsibility, expressing regret, and offering apologies. When such efforts are successful, "a gratifying shift occurs within the client from humiliation towards humility" (p. 69).

The process of deconstructing guilt, although not a lineal one, begins with identifying and putting a name to feelings of guilt and then connecting them to the hurtful behaviors. When this process occurs in therapy, the therapist seeks to clarify the client's

good intentions, separating them from the actual negative effects. As clients acknowledge responsibility for what they have done that was harmful or hurtful, they experience regret and remorse. This moves them toward "extending a full moral apology" (K. Tomm, personal communication, August 15, 2019) and enables them to take restorative action. At this juncture, the process of learning from previous errors is incorporated as a way to co-construct new competencies. A final component may include "'going public' with humility and generosity (so others can learn from one's mistakes)" (K. Tomm, personal communication, August 15, 2019).

Opening Space for Apology and Forgiveness

Key aspects of Tomm's clinical work include assuming responsibility for one's actions, apologizing, and moving toward forgiveness and reconciliation. In all ongoing relationships, particularly those within families, conflict is expected. There are times when family conflicts result in breaches of trust and deeply hurt feelings. When this happens, family members often "try to recover a sense of personal and relationship wellbeing by endeavoring to forgive and reconcile" (Tomm, 2002, p. 65), perhaps by entering therapy.

A pattern of conflict, arising as a "consequence of individual *differences* coming up against each other as time unfolds" (K. Tomm, personal communication, August 15, 2019), can be interrupted in various ways—by moving away from the area of interaction, by remaining within the interaction and concurrently keeping the escalating conflict contained, or by engaging in clarifying conversation to understand and resolve differences. As individuals continue to experience conflict, one or both of them will seek "vindication[,] a psychological healing process of restoring a sense of personal worth

after having been hurt or 'diminished'" (K. Tomm, personal communication, August 15, 2019).

When therapists encounter families who demonstrate ongoing or recurring conflict, it is typically because these family members have been attempting to vindicate themselves by retaliating. These attempts at vindication from one party invite similar attempts from the other, creating an escalating cycle of conflict. Attempting vindication as a way to heal the mind can be seen as analogous what "inflammation is for physical healing of the body, as a response to injury" (K. Tomm, personal communication, August 15, 2019). One party's efforts at vindication may come in some form of retribution aimed at decreasing the other's worth. Another way to be vindicated is to elevate one's own sense of self-worth, such as by becoming more competent, contributing to a valuable cause, or moving toward forgiveness. Yet another way is through mutual action, which can include acknowledging, forgiving, apologizing, and/or engaging in rituals with the aim of "restoring the worth of the relationship and of both parties in it" (K. Tomm, personal communication, August 15, 2019).

In his work with families, Tomm engages in conversation from a stance of social constructionism and bringforthism, to enable family members to move toward forgiveness and reconciliation. Although the parties involved in a conflict generally express feeling mutually hurt, one party usually feels more injured than the other. As Tomm (2002) explains, it is the one "who inflicted the most harm [that] needs to take more initiative to acknowledge mistakes, apologise, and take restorative action" (p. 65). In order for true reconciliation to take place, the one feeling more hurt must begin to forgive. Through the lens of interactional patterns, apologizing/forgiving is seen as "a

core healing pattern that enables reconciliation in interpersonal relationships, and potentially between groups and communities as well" (K. Tomm, personal communication, August 15, 2019).

Although there are many connections between forgiveness and reconciliation, there are also important distinctions. Forgiveness "implies a willingness to abandon resentment, to relinquish any entitlement to retaliate or seek retribution, and to foster undeserved compassion, empathy, and generosity towards a perceived offender" (Tomm, 2002, p. 66). To practice forgiveness is to acknowledge the offending person's value with "generosity and love" (p. 66), thus fostering a reciprocal response from the other, opening space for mutual forgiveness, and moving into a process of reconciliation. Tomm considers forgiveness to be more of "a spiritual phenomenon, rather than a psychological [one]" (K. Tomm, personal communication, August 15, 2019). Forgiveness provides individuals with a way to handle the feelings of resentment and anger that stem from the wrongs inflicted upon them. It has the potential to enrich their physical, mental, and spiritual well-being, as well as increase the likelihood of reconciliation. People can forgive themselves or openly forgive others in a relationship. It may be gradually and *implicitly* realized over the course of time, or it may be *explicitly* elicited through conversation, reflection, or ceremonies and rituals that honor healing (K. Tomm, personal communication, August 15, 2019).

Reconciliation, considered "a major *interpersonal* achievement" (Tomm, 2002, p. 66), works to restore breached trust. It requires the involvement of both parties. Forgiveness, which is accorded to the offender by the one who feels injured, does not require both parties nor does it precede or ensure reconciliation. Although there are times

when reconciliation may not support a person's wellbeing, "forgiveness is a worthwhile goal [that] offers the person freedom from feelings of bitterness and resentment" (p. 67). There may be times when reconciliation occurs but forgiveness does not, or when the conflict is put aside instead of addressed. The danger in this is the "risk of escalation" (p. 67), as painful memories may resurface, thus contributing to continued resentment and setting the stage for conflict to arise in the future.

While reconciliation presupposes a previous trusting relationship, trusting "entails believing that the other person genuinely 'means well'" (K. Tomm, personal communication, August 15, 2019). Trust requires believing that the other person is essentially honest and is trying to live in an authentic and genuine way; that the other shares the partner's values regarding life and relationships; that the other's intentions are good; that the other is competent to behave in accord with their good intentions; and that the other has the desire and willingness to demonstrate their competence on behalf of the partner.

When the process of rebuilding trust takes place in therapy, the therapist does not initially address the mistrust, but rather directs the family's focus to each person's raising awareness of their own trustworthiness, as well as each person's efforts to enable it. Rekindled trust "invit[es] the alleged offender to learn to 'live above suspicion'" (K. Tomm, personal communication, August 15, 2019).

Tomm (2002) identifies a series of possible steps in the process of forgiveness. It begins with "recognising and acknowledging that one has been deeply hurt and identifying one's strong feelings about having been wronged" (Tomm, 2002, p. 67) This includes knowing and letting go of those desires that may not be satisfied due to the

offence. It is helpful to distinguish between "the offender and the offence" (p. 67) and, without excusing the offence, to "develop empathy and compassion towards the offender" (p. 67). Gaining a new perspective of oneself and the offender can lay the groundwork for forgiveness to emerge. Part of the process may entail sharing the possible benefits of forgiveness while also presenting realistic obstacles to it happening. It is important for everyone—including the therapist, offender, friends, family members, and/or spiritual advisers—to avoid pressuring the victim to forgive before he or she is ready or willing to do so, as this may perpetrate a further offence against that person" (p. 67).

Once the offender has genuinely acknowledged and expressed regret for a wrongdoing, they can *request* forgiveness but cannot insist on or demand it. If the therapist recognizes that this is occurring, the therapist can invite the person asking for forgiveness "to take some leadership by forgiving the other person for not yet being willing or able to forgive" (Tomm, 2002, p. 67).

Rather than working with the victim to forgive, the therapist is better off "opening space for the perpetrator to extend a genuine apology" (Tomm, 2002, p. 67). Tomm considers this to be a way of working from the other side of the interactional conflict (apology/forgiveness). Such an approach requires the therapist to encounter and deal with various difficulties and challenges related to the offender.

By asking the perpetrator reflexive questions, the therapist can open space for an apology. Illuminating the steps "toward possible reconciliation" (Tomm, 2002, p. 68), the therapist offers the offender the possibility of feeling "good about themselves in making such a contribution" (p. 68). Emphasizing this point, Tomm references Trudy Govier's

assertion that rather than viewing the apology as an event, the therapist should approach it "as a process of acknowledging wrongs, expressing sorrow and regret, and taking restorative action to liberate the future from past injustices" (K. Tomm, personal communication, August 15, 2019).

A necessary and central aspect of apology involves the communicated acknowledgment that "the victim has . . . been hurt and suffered, . . . actually has worth and deserved better, . . . [and] should not have been treated in that way" (K. Tomm, personal communication, August 15, 2019). It also includes acknowledging the injuries that were inflicted, assuming responsibility for the individual or group's harmful actions, recognizing that the injured party's anger is justifiable, and admitting the legitimacy of the victim expecting some type of reparation.

A genuine apology has four essential elements: recognizing "the harm done and of the injustice involved" (Tomm, 2002, p. 68); acknowledging the loss experienced and related pain; expressing "deep regret and remorse" (p. 68); and demonstrating a true "willingness to take restorative action" (p. 68). A "full moral apology" (K. Tomm, personal communication, August 15, 2019) incorporates additional components that include admitting one has committed the behavior, assuming responsibility for having done so, "commit[ting] to reform oneself and not offend again, commit[ting] to make amends in some way, [and] follow[ing] through by taking restorative action" (K. Tomm, personal communication, August 15, 2019).

Even if an offender offers a genuine apology that includes all four essential elements, the victim, for a variety of reasons, may not accept it. The victim may fear that the offender will offend again or may assume that forgiving entails forgetting. This may

be accompanied by intense negative emotions or "fears of appearing weak" (Tomm, 2002, p. 68). Sometimes, victims consider certain offences unforgivable, fear they may lose certain advantages related to their victim status, or fear the loss of support from those with whom they have aligned themselves against the offender. Some victims, needing to ensure their physical safety, may cut off contact with the offender. Others, as a result of victim-blaming patterns, may have "a propensity to blame [themselves]" (K. Tomm, personal communication, August 15, 2019).

Offenders may also encounter obstacles in the way of apologizing. They may be unaware of the injury they caused, may have difficulty withstanding feelings of guilt and shame, may struggle distinguishing between good intentions and their inadvertent bad effects, may fear being humiliated or punished and avoid whatever costs may be incurred, may learn from others not to concede to doing wrong, may have a "propensity to project responsibility onto others, [or may not agree] . . . about the nature of the wrongdoing" (K. Tomm, personal communication, August 15, 2019).

By opening space for the "powerful healing dynamic of apology coupled with forgiveness" (K. Tomm, personal communication, August 15, 2019), the therapist creates a rich environment for reconciliation. Tomm recommends that the therapist should initially meet separately with each party to provide the opportunity for acknowledging "the undeserved hurts and trauma suffered, [to] encourage a shift from victimization towards survivorship, to appeal to good intentions, and to co-construct small positive initiatives" (K. Tomm, personal communication, August 15, 2019). Assuming the role of go-between, the therapist, facilitates empathic communication between the parties, encourages them to acknowledge and understand one another, and ensures that the

meeting will be safe. The therapist supports the building of trust, opens space for the emergence of apology and forgiveness, points out any impasses that may present as barriers, suggests other directions to move in, and acknowledges or even celebrates the progress that has been made (K. Tomm, personal communication, August 15, 2019).

It is through the practice of therapeutic conversations that space can be opened for clients, empowering them to recognize and untangle emotions such as shame or guilt, and helping them to "move towards self-forgiveness" (Tomm, 2002, p. 69). Therapy conducted in this way is "a form of liberation that releases emotional energy to invest in further reconciliation" (p. 69), helping alienated parties live more fully, in more connected ways, and enabling them to start co-constructing hope and responsibility.

Co-Constructing Hope and Responsibility

For Tomm (1999), responsibility involves "living consistently within an awareness of whether one likes or dislikes the consequences of one's own actions" (p. 131). The awareness is crucial and is, for the most part, created within conversation. It involves a recognition of the real "effects of one's behavior (as opposed to one's intentions)" (p. 131) and a "preference for internal coherence and consistency" (p. 131).

Generating responsibility can begin with co-constructive conversations with clients, asking questions that invite them to consider and reflect upon their actions and the effects of those actions on themselves, others, and the environment. The therapist asks clients to determine how they feel about such effects. If they are not in alignment with them, the therapist asks what they might consider doing differently, encouraging awareness of the potential choice to take greater responsibility for their actions. A critical piece of this is to highlight the distinction between the intended and "actual effects of

one's actions" (Tomm, 1999, p. 132). It is critical that therapists facilitating this process maintain an awareness of their own intentions in asking questions, as space will not be opened for increased awareness if clients perceive that they are being blamed. Tomm encourages therapists to affirm the clients, assuming "there was probably at least some positive intent . . . behind whatever action was taken" (p. 132). He emphasizes the importance of asking clients questions about the good intentions that led them to act in a particular way.

Therapists then construct questions to help "bring forth an awareness of the client's feelings about the actual effects" (Tomm, 1999, p. 133), aiming to open space for *both* honoring their good intentions *and* distinguishing the effects that were not intended and negative. By making this distinction between effects and intent, clients can "experience genuine regret for their own actions without disqualifying themselves" (p. 133). When relevant, therapists can also help clients see the effects of shame and guilt. In the last step, therapists invite clients to reflect, in a co-constructive manner, on other choices they could have made. Guided by a goal of creating consistency between desired and actual effects, therapists aim to help clients make new choices moving forward.

To help clients "become more fully aware of the actual effects they may be having on the other" (Tomm, 1999, p. 134), Tomm developed the practice of internalized other interviewing, which I will discuss in great detail in Part Two of this manuscript. He also invites clients to identify and distinguish interactional patterns that contribute to pathologizing, healing, or wellness interactions. This process can open space "for change [when clients recognize that] it is possible to turn down an invitation to engage in an old pattern and instead to enact a different kind of behavior" (Tomm, 1999, p. 135). Clients

consider the responsibility they assume for staying within a certain pattern "by accepting invitations to continue in it or for declining [such] invitations . . . and offering" (p. 135), instead, an invitation to enter into a TIP, HIP, or WIP.

From Theory to Practice

Part One has presented the theoretical foundations for Karl Tomm's internalized other interviewing. I have established Tomm's commitment to ethical practice; discussed the theories and philosophies that informed the development of his evolving clinical work; detailed the contributions he has made to various therapeutic approaches and the influences these models have had upon him; explored his stance regarding the DSM and his alternative approach to assessment; and delved into his approach to interventive interviewing. I have also discussed how he conceptualizes the problems that families bring to therapy and illuminated the processes he uses to bring about change.

In Part Two, my focus will narrow as I devote my attention exclusively to the practice of Tomm's internalized other interviewing. I will explore how it developed and how it is done, as well as identify the populations with whom it has been practiced. By comparing and contrasting internalized other interviewing with seemingly similar methods practiced within other traditions, I will highlight its unique aspects and limitations. My discussion of this practice will be supported by case examples from Tomm's clinical work, as well as from stories he has told.

Part Two: The Practice of Internalized Other Interviewing

CHAPTER VII: IOI IN CONTEXT

No family is an island. Families are embedded in a larger culture and are
profoundly influenced by it. This perspective has helped me come to a
position of seeing the notion of 'the self' as being constituted of an
internalized community, including the family.

—*Karl Tomm* (1998b, p. 411)

The first part of this chapter explores the similarities and distinctions between the
IOI approach and other therapeutic practices. In order to explore this adequately, it is
necessary to first elaborate upon the preliminary description of IOI presented in Chapter
I. In later chapters, particularly Chapters VIII and IX, I will further delineate the steps
involved in an IOI, to provide a clearer understanding of how the practice is conducted
and how it can be used with various populations.

The second part of this chapter begins with the theories and practices that
influenced and inspired Tomm to develop IOI. I explain its historical evolution, starting
with the earliest iterations influenced by David Epston, and explore the collaboration
between Epston and Tomm, which Tomm then expanded upon to develop his unique
interviewing method. I then discuss Tomm's purpose and intent in developing the IOI
approach and conclude with a discussion about the research that has been published about
it.

Description, Resonances, and Juxtapositions

In the existing literature, various models or techniques are described as being
similar to IOI in practice or having influenced its development (Chimera, 2014; Couture
& Tomm, 2014; Moules, 2010). To investigate these claims, I reviewed journal articles,

book chapters, and personal communications to discover how these various techniques resonated and juxtaposed with Karl Tomm's specific IOI approach. To contextualize the ways of working with clients that are both similar and different, I will first provide a description of IOI, followed by a brief review of Gestalt concepts, psychodrama, and Internal Family Systems. What will become evident is that while these approaches may appear to resonate with IOI, they differ significantly from it. The epistemological premises, intent, and clinical components of IOI are distinct.

Description of IOI

This style of interviewing strongly relies upon "the phenomenon of memory that is contingent on the plasticity of the nervous system to retain prior patterns of interaction" (Tomm, 2014b, p. 236). As Tomm (2014b) explains, through the process of recurrently interacting with others, "we automatically create impressions of them (and their experiences) within ourselves, which . . . become distilled into a composite *internalized other* within our memory and imagination" (p. 236). For us as humans, this occurs because of our innate propensity to "create images or impressions of others within [our]selves, which then become parts of 'the self'" (K. Tomm, personal communication, August 15, 2019). Tomm explains that "the psychological 'self' [is] constituted by an internalized community [that] includes all the past, present, and anticipated future patterns of interaction among the members of that internalized community" (K. Tomm, personal communication, August 15, 2019). Although they are never the same, "the presumed qualities and characteristics of the internalized other and the actual other are usually quite similar" (Tomm, 2014b, p. 236).

In the process of interviewing the internalized other within the individual, it is understood that the self "can be deconstructed conceptually into a whole internalized community[, consisting of] all those real and imaginary persons we have interacted with, in our actual living and in our imagination, plus all the interactions and relationships among them" (Tomm, 2014b, p. 236). When we think in these terms, space can open for us to interact with any part of "that internalized community and work systemically on relevant patterns of interaction" (p. 236). In the process of externalizing the pathologizing problems that have become internalized patterns of interaction, Tomm conceptualizes using IOI through the lens of the IPscope. Through externalization, the patterns then "become available for deconstructive TIPs (transforming interpersonal patterns) . . . [that] could potentially be replaced by HIPs and WIPs (healing and wellness patterns) and re-internalized within the individual self of the client" (Tomm, 2014b, p. 236). It is a way of working with individuals systemically and activating their internalized community in the process, thereby opening space for possibilities to emerge. Interviewing the internalized others within an individual "assists [them] to be able to see through the eyes of other family members, moving from monologue to dialogue" (Lysack, 2002, p. 219). It is a practice through which a therapist interviews "the 'internalised other' and the 'distributed self' of an 'actual other' as it exists in the person being interviewed" (Emmerson-Whyte, 2010, p. 5). As Emmerson-Whyte (2010) explains, the images individuals have within themselves of others is what is referred to as the "internalized other;" the "distributed self" refers to "how a person exists 'within' another person" (p. 5).

One way to understand internalized other interviewing is through the metaphor of culture, which draws our attention to each person's uniqueness. Applying this metaphor

to therapy helps us maintain our curiosity, guards against making assumptions, and steers us away from stances predicated on the existence of objective truths. The IOI approach was designed as a way to step into another's lived experience, offering clients the opportunity "to experience what it's like to make meaning in another 'culture' . . . [,] to temporarily inhabit someone else's skin" (Paré, 2002, p. 22).

Burnham (2006) describes IOI as "an imaginative way of enhancing the ability of persons to understand, appreciate and enhance their experience of, and relationship with, other persons" (p. 32). Looking at the interpersonal patterns in "multi-stressed families," couples, and between adolescents and their parents, Lysack (2002) observes that they are "plagued by argument, paralysed by conflict and power struggles, and locked into a series of adversarial communication patterns" (p. 220). The negative narratives family members have about each other and the family in general are reflected in their conversations with each other. They also make up the inner conversations they have with themselves about their experiences of one another. Lysack points out that IOI can be a highly respectful practice that helps families begin moving away from these negative narratives and related patterns in a way that is "generative of new inner/outer conversations" (p. 221).

Resonances and Juxtapositions

This section details the three models that share similarities with IOI: Gestalt, Psychodrama, and Internal Family Systems.

Gestalt

According to Moules (2010), "Tomm's development of [IOI] of actively interviewing the embodied other has influences from earlier works of Frederick (Fritz) Perls and gestalt therapy" (p. 188). While learning about Gestalt Therapy techniques

during the first year of his psychiatry residency in 1967, Tomm had contact with the originator of the approach, psychiatrist and psychoanalyst Fritz Perls (K. Tomm, personal communication, August 15, 2019). He was interested in experimenting with some Gestalt techniques, specifically the two-chair technique, in which the "therapist gets you to sit in another chair being the other person and [you] talk to them, and so forth" (K. Tomm, personal communication, August 15, 2019). Tomm acknowledges that IOI is sometimes compared to this Gestalt technique; however, while he and Perls "converge to similar ways of practice[,] . . . the theoretical basis is quite different" (K. Tomm, personal communication, August 15, 2019), most notably in the assumptions that underlie the origin of mental phenomena. Tomm explains that:

> in psychoanalytic theory, the origins are intrapsychic in terms of Freud's models, ego, super ego[, whereas the practice of internalized other interviewing is] grounded in the social domain, [in] that the social relationships are the ground out of which the individual rises. (K. Tomm, personal communication, August 15, 2019)

In spite of these differences, the Gestalt approach served to influence Tomm's work.

One particular practice from "Gestalt work, the two-chair technique" (Bubenzer, 1997, p. 94), serves as a juxtaposition to IOI. In Gestalt work, therapists regularly practice reintegrating the people back into themselves at the end of the interview. Tomm explains that this is not part of the IOI approach, because the assumptions of the two techniques are quite different. In IOI, the assumption is that we are always holding our internalized others with us. In fact, Tomm sometimes favors leaving "them 'in the other'" (p. 94) so they have the opportunity to "live more of their lives from that position" (p.

94). While the two-chair technique is oriented toward creating intra-psychic change that facilitates insight within the individual IOI—a post-modern practice—seeks to create change in the interpersonal space, within the relational patterns of interaction.

Psychodrama

Like systemic family therapy, psychodrama is predicated on the assumption that individuals possess the strength and ability to solve problems. In both approaches, therapists "avoid descriptions of clients as emotionally impoverished or psychologically damaged" (Chimera, 2014, p. 85). Although oriented by psychoanalytic theory, Moreno, the developer of psychodrama, saw people's problems not existing solely within the individual, but rather "as existing in the system" (Chimera, 2014, p. 85). As he worked with couples, he began to realize he was treating "an 'interpersonal relationship', or . . . an 'inter-personal neurosis'" (p. 85).

In terms of techniques, Chimera (2014) explains that "the clearest example of the infiltration of psychodrama into family therapy is the 'discovery' of internalized other interviewing by Karl Tomm in the 1990s" (p. 97). According to Chimera, IOI shares commonalities with the role reversal technique commonly used in psychodrama. After the interview is completed with the internalized other, the person witnessing it is asked to comment on the accuracy and sensitivity of the person being interviewed, which creates an opportunity for "increasing empathy, establishing connection, [and] giving [an] opportunity [to] correct . . . misunderstanding" (p. 97). Role reversal in psychodrama aims to promote "reflection and change" by giving clients the opportunity to take on another person's perspective. It, too, is followed by a discussion about the process, which includes exploration into "what it was like to be the other person, how the other person

experienced seeing him-/herself being enacted by another, [and] always giv[ing] the opportunity for correction" (p. 101). Both IOI and role reversal have broad applicability, as they offer "a way to reverse, not only with other people, but also with parts of self, internal qualities and inanimate objects . . . limited only by the imagination of the participants" (p. 101).

While Chimera (2014) points out the similarities between the two approaches, Tomm firmly distinguishes IOI from role-playing. For Tomm, the goal of IOI is to have clients "speak from the inner experience of the other[, from] . . . their experience of the other person's inner experience" (Bubenzer et al., 1997, p. 93). This is distinguishable from role-playing "surface behavior" (p. 93).

According to Vasconcelos and Neto (2003), both psychodrama and the Gestalt empty chair technique are grounded in a conceptualization of the self as "an intra-psychic entity" (p. 19). In contrast, the philosophical foundations of IOI underscore the self as co-constructed and relational in nature.

Internal Family Systems

Internal Family Systems (IFS), developed by Schwartz (2009), takes concepts from systems theory, incorporates some techniques from family therapy, and applies them to intrapsychic processes. The IFS model brings together ideas from psychoanalysis, structural, narrative, and intergenerational therapies, as well as experiences from Schwartz's clinical work (Rambo et al., 2013; Schwartz, 2013a). It is influenced by structural family therapy, particularly in its focus on subsystems and their hierarchy, and "calm and centered experience of leading from the self" (Schwartz, 2013a, p. 196) is much like the concept of differentiation in Bowenian therapy. Schwartz incorporates

elements from hypnosis, including both mindfulness and the idea of creating change in conscious awareness. The notion of promoting multiple realities and creating alternative narratives about the self are ideas borrowed from narrative therapy. As a strength-based model, IFS embraces the belief "that every person, no matter how disturbed, has access to an inner self that is both calm and confident" (Schwartz, 2013a, p. 196).

Schwartz (2004) developed the Internal Family Systems (IFS) approach while working with clients suffering from eating disorders. As clients described their experiences of binging and purging, Schwartz found himself wanting to learn more about the conversations they reported having with their internal parts. Deacon and Davis (2001) explain that when clients share their experiences of internal conflict, they frequently "identify this ambivalence or confusion as different internal perspectives or 'parts' of themselves" (p. 46). Based on this observation, Schwartz developed IFS to be "a systems theory application to those 'parts'" (Deacon & Davis, 2001, p. 46). Rather than regard emotions as problems to be discarded or let go, they can be seen as "contain[ing] valuable messages to be heeded and explored" (Schwartz & Johnson, 2000, p. 31), listened to and examined. The goal of IFS is for the Self to emerge in its innate position of leadership, so that it can learn to appreciate what the other *parts* contribute, accept them in their roles (i.e., as protectors of intense emotions), have compassion for them, and enable them to transform.

Therapists working with the IFS model are directive and influential; and they undergo the same process as the client. Based on Schawrtz's observation that clients tend to harshly judge themselves, IFS is designed to offer clients a way to reverse the negative self-judgment and polarization of the parts, such that all of them are regarded as valuable

for a "healthy mind" (Schwartz, 2013b, p. 808). The Self, analogous to the Soul, is at the core of all human beings; by accessing it, releasing it, and getting to know it, a person can allow the parts to heal (Schwartz, 2009). In its position of leadership, the Self "is the undamaged essence of a person" (Schwartz, 2013b, p. 808) and is accepting, compassionate, and focused. With us from birth, the parts are useful, all genuinely good, and there to help us; however, when we experience traumatic events, the parts get off kilter (Schwartz, 2009). Rather than do away with them, the goal is for the person to know them in a new way and recognize that they no longer need to act as protectors of the Self.

There are two basic types of interventions in IFS: *insight*, which helps individuals investigate their internal systems through the use of imagery and visualization, and *direct access to parts*, in which the therapist speaks to the client's different parts and, therefore, "act[s] as the person's Self" (Deacon & Davis, 2001, p. 48). The process begins with the client choosing a feeling or belief they want to change. The therapist then guides the client to attend to that part, locate it in the body, and explore how they feel toward it. This exploration occurs through "the hallmark question of IFS" (Schwartz, 2013b, p. 808). The therapist asks the client to locate the parts that hate the unwanted feeling or part, instructing the client to speak directly to it and ask it "to open space inside" (p. 808) so they can become better acquainted with it. In speaking directly to parts, the client "becomes a therapist for his or her family of internal parts" (Deacon & Davis, 2001, p. 49), recognizing them and creating change through dialogue. Guided by the therapist, the client gains awareness of their "inner resources related to the Self" (Green, 2008, p. 127) and sees that by connecting with the Self and permitting "it to lead the internal system[,

they] can yield an external life of balance and harmony" (p. 127). This therapy helps "the inner subpersonalities" (p. 127) to elevate their awareness of the loving Self such that the client "can relax . . . , understand . . . [their] internal world, and relate to the Self and to others in a psychologically healthier way" (Goulding & Schwartz, 1995; Schwartz, 1995, as cited in Green, 2008, p. 127).

Although it involves working with internalized "parts," IFS does not resemble IOI in terms of its epistemology, theoretical assumptions, intended goals, or clinical practice. The work is intrapsychic rather than interpersonal, and individualistic rather than relational. Although Schwartz incorporated ideas from narrative therapy in the creation of IFS, the model's entire premise is largely modernist. For example, it is based on assumptions such as the possibility of objective truth, the therapist as an expert and outside observer of the system, and the whole as the sum total of the parts. Additionally, the process of identifying the parts, which are related to traumas or emotional pain experienced earlier in life, is largely focused on the past. The primary focus of the model is a multiplicity, not a multiverse, of internal parts. This is in direct contrast to the systemic, relational, social constructionist and bringforthist work of IOI, in which clients' understandings of their internalized others occur in the here and now, and in which multiple perspectives are valued. As an integrated model that draws from many sources, IFS combines ideas and theories from both modern and post-modern perspectives. This represents another significant contrast between IFS and IOI, since IOI emerges fully from the tenets of post-modern thought.

In both IFS and IOI with couples, the therapist works with one individual while the other is observing. However, what the therapist invites clients to observe is quite

dissimilar, and it is done for distinctly different purposes. In IFS, observers attend to their partner's internal parts, and to how their partners are addressing them and understanding them. This allows observers to gain greater insight regarding their partners' intrapsychic state. As they listen, observers are urged to also listen to their own parts. When speaking, they are encouraged to do so from the Self, expressing what the parts are feeling (Schwartz, 2013b).

Conversely, in IOI, the observers—known as the actual other—attend to their partner's experience of the internalized other and to their own distributed self within their partner. The therapist invites the actual other to ask questions in order to assess the degree of resonance between their partner's understanding of their experience of the internalized other and the actual other's experience. This is used as a platform upon which to co-construct movement in the direction of change. In IOI, change is not defined by greater insight, as it is with IFS, but rather by the generation of solutions to the problems. On the surface, IFS and IOI may appear to be similar in practice, as both work with internal concepts; however, because of the differences outlined above, they are distinctly different.

In describing IOI and comparing it to other models and approaches that have been described as similar to it, the distinctions between the models and IOI can be more easily discerned. In the next section, I will broaden the context of IOI and explore its evolution, the intent behind its development, and the research on it that has been published to date.

Development, Purpose, and Research

Before outlining the format and steps of the IOI approach in Chapter VIII, I will present a brief history of its development. To understand the nature and structure of IOI,

it is important to examine what led to Tomm's expansion and further development of the original concept—the experiences, collaborations, and inspirations.

Tomm's IOI: Influences and Inspirations

Reflecting on the steps he took toward developing IOI, Tomm recalls that his earliest influence occurred during his psychiatry residency, when he first learned about Gestalt therapy, including the two-chair technique, and had "some contact with Fritz Perls" (K. Tomm, personal communication, August 15, 2019).

After working with the Milan team for a number of years and developing his systemic therapy skills, Tomm began to collaborate with Michael White in 1984 and was later introduced by White to David Epston. In 1988, during a workshop in Calgary that Tomm invited him to attend, Epston described an interview he had with a couple who fought so intensely during the session that he could not intervene. In an attempt to disrupt the fighting and move the session along, Epston stood up, yelled, and asked the couple a question they had never heard before. As he listened to this story, Tomm was intrigued by the technique Epston was describing. He later attempted to use it with a family, but found that it "didn't work" (K. Tomm, personal communication, August 15, 2019).

The following year, at a conference in Calgary at which Cecchin and White presented their work, Janet Bavelas raised a concern about both presentations, wondering about the field of family therapy "losing some of the richness of interpersonal interaction . . . [and] focusing so much on individuals . . . [, which] generated a very energetic dialogue" (K. Tomm, personal communication, August 15, 2019). In the aftermath of the conference, Tomm continued to reflect on the thought-provoking discussion. He theorized that if he could conceive of "the individual as being constituted by their

internalized community [of others] . . . , then it became possible . . . to deconstruct the individual into this collective" (K. Tomm, personal communication, August 15, 2019). Tomm recognized that this conceptualization enabled him to interview any member of a particular community. With this new understanding, he once again attempted Epston's technique, this time finding it successful. Upon sharing his success story with Epston, the two decided to collaboratively present this practice at the Tulsa Therapeutic Conversations Conference in 1990. Epston presented first, and as Tomm listened to him, he noticed an important distinction. Whereas Epston described using "interpersonal perception questions," he described using "internalized other questions." More confusion arose for Tomm when Epston referred to his questions as "cross-referential questions." Shortly after this presentation, they both came to use the same terminology, *internalized other interviewing questions,* and each agreed "to write a paper . . . . He wrote his, and I didn't write mine, his got published and mine didn't . . . [I] still haven't written about my perspective on this work" (K. Tomm, personal communication, August 15, 2019). Since then, Tomm stated he has been using this practice "intermittently . . . [,] find[ing] it really fascinating and useful" (K. Tomm, personal communication, August 15, 2019).

Historical Evolution of IOI

Although the earliest iteration of IOI originated with David Epston, what was first used as a clinical intervention evolved and transformed. The following section describes the process of IOI's development, from its preliminary beginnings to the practice as Tomm describes it today.

Epston's "Cross-Referential Questioning"

David Epston (1993) used the term "cross-referential questioning" (p. 183) to refer to his personal practice of asking questions, which grew from discussions he had with Karl Tomm. Epston credited Tomm with expanding its use to other contexts and inspiring "the designation of 'internalized other questioning'" (p. 183). Epston specifically designed this method of questioning, known as "the New Zealand version" of internalized other questioning, "to disrupt those warring couples who construed couple counseling as a venue to contest their differences" (Epston, 1993, p. 183). Such a way of asking questions permitted Epston "to decline the 'couple's prescription for the therapist' . . . and permit the couple to step into each other's experience" (Emmerson-Whyte, 2010, p. 4).

Epston saw these couples as falling into three basic domains of roles and behaviors, each resulting in an oppositional stance. For those assuming the domain of the courtroom, he saw the therapist, whose task is to determine innocence or guilt, in the role of judge. The individuals in the couple each provide evidence for their side of the story. The second domain, "the ecclesiastical court or Inquisition" (Epston, 1993, p. 183), resembles the courtroom domain; however, rather than right or wrong, the issue involves morality or lack thereof. Accordingly, the therapist's job is to determine which party is innocent or sinful. In the third domain, each partner assumes the role of "psychiatrist/neurologist" (p. 184), placing the therapist in the role of a "consulting expert" who is tasked with determining which partner's worldview deserves more weight. Epston found that he needed a way to avoid being recruited into one of these three roles. Devising a format for questioning was a way for him to decline these invitations to join

in, and instead, provide the partners with a chance "to experience something of the other's experience" (p. 185).

For Epston, this process consisted of a line of questioning that began with a *prologue*, which addressed what the clients have been experiencing and why it has not resulted in an acceptable outcome, thus leading them to seek therapy. Epston then explained to the clients his rationale for not asking them similar questions to the ones they have been asking themselves and each other; instead, he would ask a series of questions unlike anything they had heard before. Next, he invited the clients "to experiment with some questions that conceivably could lead to a reunion in [their] relationship" (Epston, 1993, p. 185).

Following this invitation, Epston presented the clients with an *apology,* a warning about the difficulty they may experience as they engage in the process of interpreting and responding to the questions posed to them. After the couple agreed to move forward, Epston explained the process. One partner opts to be first in answering the questions; the second person must listen to the first one's answers. Next, both partners respond to the same questions and then share their impressions about the extent to which the other person understood their experience. Following the questioning of each partner, Epston engaged the couple in a discussion, during which he cross-referenced their responses. He frequently ended this first session by joining the different accounts the couple provided of their relationship and providing a summary of what transpired, often in the form of a letter to the couple. Throughout the letter, Epston (1993) used "double externalization" (p. 189) to refer to the problems that each partner described experiencing in the

relationship, and to emphasize how the process of therapy could help determine what direction their relationship might go.

Epston (1993) found that this practice often led clients, "(especially men) to reflect in unusual ways" (p. 187), going on to explain that "the partners seem willing and curious to hear each other out without interruption . . . , with each person digging deep into his or her experience of the other" (p. 187). He saw the potential for this practice to assist people in finding new strategies and either recovering previous ways of organizing their relationship or developing new ones. Epston asserts that couples understand their problems through the lens of their own objective reality. Hence, their behaviors, in reaction to this understanding, result in ways of relating to one another that are damaging to their relationship. He proposed that asking questions that invite individuals to respond from their own experience of the other's experience can have "the effect of undermining those cultural practices that affirm an objective reality" (p. 189). In a commentary on Epston's practice of IOI, White likened it to what he identified as "'experience-of-experience' questions" (Epston, 1993, p. 194). Though he was already familiar with this style of questioning, he credited Epston's practice of interviewing a partner's internalized other as being "a distinct development in his work" (p. 194).

Tomm's Internalized Other Interviewing

Expanding upon his collaborative work with Epston, Tomm expounded considerably on the original concepts of IOI "by developing and formulating a comprehensive body of theory to support . . . this practice" (Emmerson-Whyte, 2010, p. 4). His social constructionist perspective and commitment to Maturana's theory of cognition informed his development of the practice of IOI (Bubenzer et al., 1997; Tomm,

1998a). A number of journal articles written about Tomm's practice describe it as operating from within a social constructionist frame, conceiving of the self as being "created within clusters of conversations which are internalized[,] . . . sorted in terms of preference and called forth in other social conversations" (Burnham, 2000, p. 16).

Language, which arises over time from social interactions within one's culture and history, "is regarded as generative and constitutive of human experience" (Lysack, 2002, p. 229). The self does not exist in isolation, but rather emerges in relation with others. Accordingly, "our 'inner' life consists of a polyphony (or . . . a cacophony) of voices in conversations, or images and 'echoes' of interactions with others" (p. 230). An individual's identity as a self in dialogue expands to include those with whom they are in dialogue; these individuals form and establish their sense of self. Viewed within a social constructionist framework, the internalized other is not conceived as internal, but as *internalized*, denoting it as "social rather than psychological . . . [and] a process that is *inter-personal* not intra-personal nor intra-psychic" (Emmerson-Whyte, 2010, p. 6).

The individual, according to Maturana's theory, exists and "arises in the unique reflections that occur at the intersection of a particular bodyhood and a particular personhood" (K. Tomm, personal communication, August 15, 2019). Thus, the "self" "is not skin-bounded but is brought forth in the continuous interactions between a person and her/his environment, including other actual persons," so that our "selves" become internalized by others (K. Tomm, personal communication, August 15, 2019). We, therefore, become distributed among all the individuals in our communities with whom we are in relationship, as our distributed selves.

Maturana, with his "emphasis on love in the process of social interaction in generating language[,] favors the centrality of the family in the creation of knowledge among its members" (Tomm, 1998b, p. 411). As conceptualized in both social constructionism and bringforthism, families do not stand alone; rather, they are set within a community, a larger culture of profound influence. In his understanding of the mind as social, Tomm considers mind to be comprised of the myriad relationships—the community of internalized others—we have and have had with significant people in our lives. It also includes those individuals who have come to be a part of us through stories and readings. Seeing the mind as social and the self as being comprised of and inhabited by a person's internalized community, Tomm is able to interview any member of this community as part of the self, as well as part of the community in relationship with the person being interviewed. In this way, Tomm has the ability to interview both the internalized other—that is within the one being interviewed—and the distributed self of the internalized other. As Tomm explains, when encountering or interacting with another person—i.e., the actual other—"one is implicitly 'always already listening' to the 'Internalized Other'" (K. Tomm, personal communication, August 15, 2019).

Tomm explains that he maintains an interest in learning about his own distributed self, "the 'distributed Karl'" (Tomm, Hoyt, & Madigan, 2001, p. 246), who, in addition to the Karl within himself, resides within the individuals with whom he is in relationship. When clients listen to their internalized other speaking through the actual other, they can become more acquainted with their distributed selves and "come home to [themselves] in a new way" (p. 246). The phenomenon of the distributed self is highly relevant for couples and serves as a significant element of the debriefing portion of the interview.

While one member of the couple is interviewed as the internalized other, the actual other observes the interview and witnesses their distributed self being interviewed within the other person. The one observing "meets herself as she exists within him . . . [,] part of her distributed self, because it's outside of her skin. But it's in her . . . network of relationships" (K. Tomm, personal communication, August 15, 2019). Thus, two interviews are simultaneously occurring; the therapist is interviewing the distributed self and that of the internalized other, increasing the "complexity, but also the richness of this . . . kind of work" (K. Tomm, personal communication, August 15, 2019).

The phenomenon of the internalized other can be observed in a two-to-three-year-old child engaged in play. As the child plays with an object, such as a doll, and interacts with it as though it were the child, the actual child can be observed speaking to the object—to themselves—from the position of the internalized parent (K. Tomm, personal communication, August 15, 2019). Tomm considers this "a pan-cultural phenomenon that . . . happens . . . by virtue of the human development phenomena and the . . . recurrent interaction with others" (K. Tomm, personal communication, August 15, 2019). In practice, Tomm has used this interviewing method with children as young as three years old.

In our relationships with others over time, "we become populated with a vast array of internalized others, [with] stories about those others, as well as stories about our relationships with those others" (K. Tomm, personal communication, August 15, 2019). Although they endure within us long past the points of interaction, those internalized others continue to affect our behaviors, feelings, and thoughts. Thus, when clients come to therapy, they bring with them those "previously internalized patterns" (K. Tomm,

personal communication, August 15, 2019) that therapists can help bring forth and seek to change through IOI.

Tomm notes that there are three ways in which therapists can ask clients about others. Direct questions are one approach that therapists can use; however, they should keep in mind that they can be a constraining way to gather information and tend to privilege objectivity. Interpersonal perception questions allow therapists to open space for multiple perspectives, privileging subjective assumptions, and creating opportunities for possibilities to emerge. The third type, internalized other questions, "privilege subject-dependent assumptions and embodied knowledge" (K. Tomm, personal communication, August 15, 2019). They offer a way of inviting people to speak from their experience of another person, thereby granting entry to a wider foundation of knowledge.

Purpose and Intent of IOI

Tomm (1999) developed IOI "as a method for helping clients get in touch with the experiences of the other" (p. 133). This was based on his assumption:

> that as we grow and develop within our relationships, we make distinctions about others and retain (within ourselves) our understandings of their actions and feelings and our experience of their experiences as memories, perhaps in the form of concatenated internal conversations about these persons. (Tomm, 1999, pp. 133-134)

With this understanding, Tomm has been able to facilitate change in the internalized other's position in relationship to the person, as well as to the other relationships of the internalized community. The interaction with both the internalized other and the actual

other creates the potential to influence the interactional patterns between them. The process of IOI can assist clients in "gaining a different perspective, and deeper appreciation of the other's position" (Burnham, 2000, p. 16). It offers a way to bridge the chasm and address the needs of all members of a family, regardless of whether they are present or not.

As previously discussed, Epston noted that couples often take adversarial positions in relation to one another, which often imposes on the therapist the need to take a position. It can also lead the therapist down the path of pathologizing the couple, seeking to remedy what is determined to be dysfunctional. For therapists, IOI offers a way to move away from "adopt[ing] a finger-wagging orientation that fails to promote responsible or empathetic behavior" (Paré, 2002, p. 28). When one client's view is considered the valid or legitimate one, the other person's position goes unconsidered, as does their experience. The practice of IOI can create space for partners to gain a greater awareness of the effects of their actions. Rather than responding to a behavioral effect question and viewing the other person's "'culture' from a distance, . . . [IOI invites] him to 'inhabit' it: to *experience* her experience" (Paré, 2002, p. 23).

As couples engage in limiting patterns of interaction and perpetuate monologues or conversations that bring up past situations and bring them into the present, "the 'same-old-story' blinds a couple to the rest-of-the-story" (Emmerson-Whyte, 2010, p. 7). Formed in the past but reflected in the present, the distributed self can wither away if no effort is made to maintain it in ways that are "vital and current" (p. 8). Movement toward patterns of wellness may "depend upon each person . . . being able to remake themselves as they exist in the other" (p. 8). The IOI approach can create space for dialogue in the

context of the therapeutic conversation, offering a "scaffolding that assists people to re-author themselves and their relationships as they exist in the other" (p. 8). It is a practice that allows individuals to establish "a greater sense of moral agency to design futures" (p. 8) that they choose, so that they can exist in relationship according to their preferred ways of doing so.

When a person starts to inhabit another's experience, the person also connects more fully with their own experience. As Paré (2002) asserts, it is a process of "self-discovery; it's about connecting with what we share as human beings" (p. 27). The IOI approach is a means of fostering "a compassionate way of knowing" (p. 28), offering one the opportunity to experience the other person's experience, and to bring "forth knowledges that are available to them, but not previously accessed" (p. 28).

Family members are invited to make a distinction between the internalized other's experience and their own experience of that person, while remaining in relationship with the person being interviewed, as well as with the person's experience. Identifying the distinctions between one's own experience and that of their internalized other opens space for new perspectives and actions, and for assuming more responsibility for one's experience (Bubenzer et al., 1997).

Research Studies of IOI

Two research studies of Karl Tomm's practice of IOI have been published, one quantitative and one qualitative. In the quantitative study, Brosh (2007) conducted an exploratory empirical study of the immediate and short-term therapeutic effects of interviewing couples using internalized-other interviewing questions. The researcher compared the IOI interview with a standard interviewing method to determine whether

the practice of IOI is "therapeutic, non-therapeutic or counter-therapeutic" (Brosh, 2007, p. 74). The participants were comprised of thirty-two married couples ($N = 64$), who were randomly assigned to each type of interview (Group A to the standard interview and Group B to the IOI). Self-reported measures were taken after the initial interview to investigate session impact. Self-reported measures were taken at baseline (prior to the initial session, at one- and at four-weeks, evaluating marital satisfaction, closeness, empathy, and intimacy.

The participants in the study (couples) were recruited from the researcher's university and surrounding environment and had to meet the following criteria: were married and living together; were at least eighteen years of age; and, husband and wife both reported desire for their relationship to improve. The study was conducted at the researcher's university in a therapy room within the psychology department.

Participants completed multiple questionnaires to assess their levels of marital satisfaction, closeness and intimacy, and their perspective-taking abilities. These were provided to the participants in random order, and completed in separate rooms independently prior to the initial interview. Following the interview, each individual completed questionnaires that were assigned randomly prior to the session. One week following the initial interview, the couples returned to individually complete a portion of the same questionnaires they had previously completed. The participants returned once more for a second follow-up visit, four weeks after the initial interview. Once again, they completed the same questionnaires they had completed in the first follow-up session at one-week, individually and in separate rooms.

Specific measures were administered to the individual participants three times: at pre-session, at one-week, and at four-weeks. To measure marital quality and satisfaction, the researcher used the Marital Adjustment Test (MAT) (Locke & Wallace, 1959, in Brosh, 2007, p. 38). Perspective-taking and empathy were measured using the Dyadic Perspective Taking Scale (Long, 1990, in Brosh, 2007, p. 39). To measure the level of relationship closeness in behavioral terms, the Relational Closeness Inventory (RCI) was used (Berscheid, Snyder, & Omoto, 1989, in Brosh, 2007). Assessing the level of intimacy that each spouse experiences was measured by the Miller Social Intimacy Scale (MSIS; Miller & Lefcourt, 1982, in Brosh, 2007, pp. 42-43).

To measure relationship closeness and connectedness from the perspective of the individual, the Inclusion of Other in the Self Scale (IOS) was used (Aron, Aron, & Smollan, 1992, in Brosh, 2007, p. 40). This test was given three times as well, however, it was used post-session, following the initial interview. Another measure used to assess closeness and level of connectedness in the relationship, the Subjective Closeness Index (SCI), was administered one time at the pre-session (Berscheid et al., 1989, in Brosh, 2007, p. 42).

Certain measures were administered one time only, following the interview (post-session). One of these measures was the Session Evaluation Questionnaire (SEQ), administered to evaluate the therapy session's immediate impact (Stiles, 1980, in Brosh, 2007, p. 43). Another measure, the Revised Session Reactions Scale (RSRS), assessed how helpful or hindering the therapy session was (Reeker, Elliot, & Ensing, 1996, in Brosh, 2007, p. 44). Additionally, the Couple Therapy Alliance Scale (CTAS) (Pinsof & Catherall, 1986, in Brosh, 2007, p. 45) was used to assess "clients' perceptions of the

therapeutic alliance in the context of couple therapy" (Brosh, 2007, p. 45). To rate the

client's perceptions of "the therapist's expertness, attractiveness, and trustworthiness"

(Brosh, 2007, p. 46), the Counselor Rating Form–Short Version (CRF-S) was

administered (Corrigan & Schmidt, 1983, in Brosh, 2007, p. 46). Finally, an instrument

developed by the researcher, the Social validity-Client's satisfaction questionnaire, was

administered to measure "the overall quality and impact of the interview session . . . .,

whether the interview session facilitated more closeness, understanding, empathy and

greater appreciation between the two spouses" (Brosh, 2007, p. 47), assessing the

session's value and meaning.

The results revealed that there were no differential effects on marital satisfaction

or empathy, on session impact or the therapeutic working alliance, or in terms of

therapist's characteristics. Both types of interviews—standard and IOI—yielded a

positive therapeutic impact. However, the male participants reported a preference for the

standard type of interview over the IOI, whereas the females preferred the IOI.

Regarding the limitations of her study, Brosh (2007) noted that the results "should

be cautiously interpreted" (p. 89), citing issues with sample size and pointing out that all

participants volunteered and none met "the criteria of being clinically distressed" (p. 89).

She also indicated that her chosen methodology presented limitations, as "the quantitative

paradigm may reduce subjective and a rich psychological phenomenon into numbers" (p.

91). Accordingly, she recommended the use of qualitative research methods to better

"tap the subjective and idiosyncratic experience of the individual" (p. 91), thus eliciting

deeper, fuller, and more abundant descriptions.

According to Mudry et al. (2016), descriptions of IOI abound in the literature; however, the effectiveness of this practice has yet to be evaluated. Interested in exploring how Tomm's practice of IOI engages clients in conversation and what might ensue from this type of conversation, the researchers designed a study to examine IOI as a discursive practice. The purpose of this study was to look at IOI in terms of both process and outcome, focusing on interactions that occur within the IOI dialogue and exploring what is "accomplished in and as a result of those interactions" (Mudry et al., 2016, p. 169), and examining the observable developments in the language that is exchanged.

Mudry et al. (2016) incorporated three discursive methods to analyze the same portion of a transcript, obtained from an archival videotaped conversation of Tomm using IOI with a mother and her adolescent daughter. The researchers used this particular video at the recommendation of Dr. Tomm; it is a conversation he considers as "exemplifying his successful use of the IOI and one he uses for teaching purposes" (Mudry et al., 2016, p. 171). Additionally, in the video, the family members communicated to Dr. Tomm their appreciation for the IOI and stated it was a helpful session. The researchers then chose the specific passage to use for their three discursive analyses. One method, Gubrium and Holstein's narrative analysis, "attends to relevant contextual features in how stories in therapy, like unvoiced stories of an internalized other, are discursively invited and elaborated" (Mudry et al., 2016, p. 169). The results of using this method "highlighted different contextual features relevant to initiating and using the IOI" (p. 181). The researchers noted that the questions asked in IOI encourage a departure from conventional conversation and delve into ways of speaking that differ from what clients have experienced. Invitations to speak in this distinct way can elicit "improvised

dialogues that can be adventures into the unfamiliar and possibly unacceptable" (p. 181). Accordingly, the researchers assert that it is critical for therapists to attend to the use of questions as a form of intervention, particularly when first using an intervention such as IOI (Mudry et al., 2016).

The second discursive method utilized by Mudry et al. (2016) was Fairclough's critical discourse analysis, which looks at cultural and institutional discourses that both therapists and clients use to push past recurring and problematic patterns of interaction. The use of this method demonstrated that the discursive collaboration taking place in IOI dialogue can challenge dominant discourses.

Ethnomethodologically informed discourse analysis, the third method utilized by the researchers, looks closely at conversational accomplishments. The results from this analysis revealed IOI as a constructionist practice that "underscored how preferences are at stake in the identity work of therapeutic dialogues" (Mudry et al., 2016, p. 181). With this method, the researchers demonstrated that "identity was accomplished explicitly . . . or performed in a more implicit yet preferred way" (p. 181), making evident the "taken-for-granted micro features of therapeutic conversations" (p. 181), and encouraging therapists to attend more closely to such dynamics in therapy.

The authors assert the importance of looking closely and seriously at construction and deconstruction, seeing it "as a central and researchable feature of human affairs" (Murdy et al., 2016, p. 180). They agree that IOI is "a constructionist practice" (McNamee & Gergen, 1992, as cited in Mudry et al., 2016, p. 180), one in which clients and therapists co-construct the interview process and outcomes together. Combining the results from the three discursive methods that looked at constructionist conversational

practice, the researchers demonstrated how any conversational intervention may be used in therapy, by closely examining dialogue.

The authors noted that interventions, such as IOI, are frequently described in terms of protocols to be followed, but emphasized the importance of looking more intently, as "any conversational intervention in therapy involves aspects of dialogue to be introduced, accepted, and made use of" (Mudry et al., 2016, p. 181). They found that the three aspects of discourse they identified in IOI are all parts of the conversational work of therapy. Thus, in therapy, conversation determines how contextual features present themselves within interventions such as IOI, "how meaning making may be dominated" (Mudry et al., p. 181), and in what ways micro-interactions that occur during an intervention can enable relevant therapeutic accomplishments. The researchers asserted that their analyses can be useful for therapists seeking to make therapeutic conversation "collaborative and preference oriented . . . [and for attending to] a 'back and forthness' in this conversational work that is often missing from the interventions literature" (p. 182). With their focus on interaction in the present moment, the researchers found that accomplishments were evident in session. However, they were unable to determine whether those accomplishments endured beyond the session.

By examining a portion of an IOI dialogue, the researchers were interested in bringing a heightened sensitivity to therapists for them to look more closely at "what transpires in the immediacies of their talking with clients" (Mudry et al., 2016, p. 182). It is possible to construct therapeutic outcomes using IOI, as it is with other conversational practices, "only if therapists mindfully and reflexively" (p. 182) think about the ways they use these practices and attend to the responses they elicit. The researchers concluded

that IOI, as a constructionist conversational practice, invites clients into a distinct type of

dialogue that is different from what they might have anticipated, and thus, "much can be

gained from attending to what goes into and from its use" (p. 182).

CHAPTER VIII: THE INTERNALIZED OTHER INTERVIEW

It certainly is a practice, but it . . . reflects a way of thinking that . . . is

even more significant. If one thinks of the self [as] emerging from a

history of interaction with others, . . . and then those others get

internalized and become part of ourselves, that organizes us—then that

perspective . . . opens space for a lot of therapeutic possibilities, . . . which

are not obvious if you just think of it as a technique.

—*Karl Tomm* (personal communication, April 20, 2020)

This chapter serves as a guide for conducting an IOI. In it, I present the steps

involved in the process and describe the processing and de-briefing that take place in the

post-interview portion of the session with clients, when they respond to the therapist's

questions and speak as their actual selves. In this chapter, I also describe the various ways

in which an IOI can affect the interviewer, interviewee, and/or the relationship and

review essential features specific to this practice. Exploring various ways that IOI can be

applied, I present the range of possibilities and techniques that can be used in this type of

interview. As mentioned in Chapter I, the final section of this chapter presents a detailed

overview of the limitations, special considerations, and contraindications associated with

IOI in clinical practice.

Throughout this chapter, I provide clinical examples to illuminate the many

aspects of the IOI approach. I derived the case examples and transcripts from notes I took

during my externship at The Calgary Family Therapy Centre in August 2019, while

viewing recorded therapy sessions of four IOI sessions conducted by Karl Tomm. With

each case example, I include a brief summary for context.

Steps in the Process

Tomm has proposed a sequence for conducting the steps involved in an IOI. Offered as a guide rather than a defined linear model, the suggested progression is as follows (K. Tomm, personal communication, August 15, 2019):

- Ask the interviewee if they are ready to speak from their inner experience of the experience of an-agreed-upon other person.

- Using the name of the other, ask the IO for permission to address them, and ask how they feel about being brought into the interview situation.

- If there is any hesitation, ask the IO about what might make it easier to accept entering into this "experiment" and then pursue possibilities.

- Ask the IO what they appreciate most about the interviewee as a person; ask what else they respect and/or admire about the interviewee.

- Ask the IO what they appreciate most about their relationship with the interviewee; then ask what they are most concerned about in the relationship.

- Ask the IO what concerns they have about the interviewee as a person.

- Ask the IO what they would appreciate most if the interviewee was willing and able to make some changes. Then ask about how these changes could be manifested and inquire about other changes in the interviewee that the IO would appreciate.

- Ask the IO what other questions might be useful to ask in order to understand their relationship better (a meta question) and pursue any leads.

- Say goodbye to the IO and ask for the interviewee's honest guess at what percentage of their answers the other might agree with. Raise uncertainty.

- Invite the observer's comments. Then discuss the whole experience.

Prior to explicating the interview process in greater detail and illustrating it with clinical applications, I would like to present some of the observations I made as I reviewed the recorded transcripts of Tomm's clinical sessions. First, I identified commonalities in the way Tomm practiced across the four cases. In all of them, he joined the session as a consultant, meeting the clients for the first time in the presence of their therapist. At the time of Tomm's intervention, the primary therapist in each of the four cases had met with the family for a few sessions. Tomm began each case consultation by asking the therapist and clients about the course of therapy, the goals, and how everyone perceived the progress up to that point. He then asked each client in the room to identify their main concern and describe what would be useful for them to work on in the session. Tomm invited the clients to participate in the IOI, which he frequently referred to as an "experiment." In two of the cases, he presented this invitation approximately 15 minutes into the 90-minute session, and in the other two at around the halfway point.

When working with IOI, Tomm introduces the practice to the clients before they agree to experiment (Bubenzer et al., 1997; Lysack, 2002). First, he explains that people become more familiar with one another as they live with each other, as we "build within us an image of that person and a sense of what is going on for them." (K. Tomm, personal communication, August 15, 2019). Emmerson-Whyte (2010) describes this as a way to invite the couple "to step out of an adversarial conversation and into a space where they can talk in an unprecedented way about their relationship" (p. 9). He explains this occurs by an individual internalizing how they perceive and experience the other person, which then becomes part of the person, and yet, at the same time, remains different. In other words, while one's perception of the other overlaps with how that other

is perceived by others, it also remains distinct. In pointing this out to clients, Tomm reviews what is similar, what is different, and where there is overlap between the person being interviewed and the internalized other. Explaining to the clients that they can expect for there to be "gaps in their understanding of the other person" (Lysack, p. 233), he assures them that this is a routine aspect of the process. To pique their curiosity, he states that the aim of the IOI process is "to get a better appreciation, understanding, of where the other person's coming from" (K. Tomm, personal communication, August 15, 2019).

In the transcript that follows, Tomm (KT) is speaking with a couple, John and Alice, who separated one year ago. They have been in therapy working toward the goal of co-parenting their two sons, ages 19 and 3.5, who are currently living exclusively with Alice. In this transcript, Tomm introduces the idea of IOI to the couple (K. Tomm, personal communication, August 19, 2019).

> KT: Let me just ask you—this might be a bit unusual for you. I'm wondering if you'd be okay with me doing a little experiment with you. 'Cause what I think is useful sometimes is when people are having difficulty communicating, when they come to understand the other person's perspective better, it helps a lot. Right? And when people don't understand each other, . . . that leads to more conflict and people make assumptions sometimes[,] . . . differences come up against each other[,] and conflict arises. So, in the experiment I'd like to propose, . . . and I do this with families from time to time, because sometimes it's helpful. There's no guarantee it will be, but it might be helpful. What I do is interview each of you in the other while the other observes. So, for instance, I could interview Alice in

you, (turning toward John) while Alice observes. . . And what I'll be asking you to do is speak from your experience of her experience, realizing you can never know with absolute certainty what's going on inside her. But you have some hunches. Right?

John: Mmhmm

KT: So, your internalized Alice is going to be somewhat different than the other Alice. But the similarities and differences are gonna be interesting to look at afterward, because after I talk to, say, Alice within you for a while, then I can explore with her what fits, what doesn't fit and so forth, and similarly, I can interview you in her, right, and then you can respond the same way. So [are] you guys willing to do that today, just as an experiment?

In this example, Tomm introduces the idea of having a different sort of conversation in the therapy session, "as an experiment" (Lysack, 2002, p. 232), intentionally adding that others have previously found this process helpful. He invites the clients "to speak the unspeakable" (Bubenzer et al., 1997, p. 93), encouraging them to imagine what the internalized other might feel but may not say. Tomm makes clear that the aim of this process is for clients to "get more deeply in touch" with their experience of the other's experience (K. Tomm, personal communication, August 15, 2019). This is intended to guide the clients into the experiential realm, as is addressing the person repeatedly, using the name of the internalized other "to ground the questioning" (Bubenzer et al, p. 93).

When the internalized other is present, as in the case of a couple, Tomm precedes his questioning by inviting the actual other to write down what might resonate with them

as similar or different from what is being stated, asking them to notice "what fits [or] doesn't fit" (K. Tomm, personal communication, August 15, 2019). He tells the client that these observations will be reviewed after the interview. Tomm then suggests to the two clients that they situate themselves in chairs that are placed at some distance from one another, so that the person being interviewed can concentrate "without feeling under the gaze of their partner" (Paré, 2002, p. 25). For the one observing—the actual other— the distance can help diminish the inclination to be pulled into the interview and lose focus.

The family in the next case consists of a mother, Janice; her boyfriend; and her teenage son, Derek. Upon meeting the clients, who have already met for three prior therapy sessions, Tomm sets out to establish a focus for his consultation (K. Tomm, personal communication, August 20, 2019).

KT: What do you think might be useful to talk about today? A good focus for today's meeting?

Son: Get along better with mom.

Mom: Agree. Better communication.

As the session continues, Tomm introduces IOI to the family members, explaining its rationale, inviting them to participate, and instructing them about the process prior to beginning the interview. This case demonstrates Tomm's way of elaborating on the idea of the internalized other, in this case illuminating how the mother and son have both come to be internalized within one another.

KT: I'd like to do an experiment with you today. [It] has to do with a way of understanding another person. When people understand each other better, they

can make better choices about how to get along—to enhance your understanding of each other.

[Here's how it works:] I talk to you as if you were the other.

KT (addressing Janice): Through living with [Derek] all your life, you've obviously internalized him and he's part of you, in terms of your ideas of what he's like, what he thinks, and so on. And that internalized [Derek] is part of you. Right? Now if I speak to you as if you were [Derek], I'm drawing out that internalized understanding you have of him and as he then listens to that, he can see whether it fits for him or not—what connects, what doesn't connect, and so forth.

KT (addressing Derek): And then we can ask you what part of her answers fit for you and what doesn't. Right? And similarly, I can speak to your internalized mother, because you obviously have a sense of what your mother thinks or expects and so forth. Your understanding may not be 100% correct. And when I speak to you as if you were your mother, then she can listen in and see what fits and what doesn't fit. And then you can give each other feedback and that, sometimes, is useful—to work towards better understanding.

KT: So, are you willing to do that today? Just as an experiment?

(Janice and Derek both agree)

KT: Okay. Who wants to go first?

(Janice volunteers to be interviewed first.)

KT (directed toward Derek): While I'm talking to you inside your mother, [Derek], if you want to make some notes, jot down some answers to the questions

I ask--[and] if you have a good memory, you don't need to take notes. [But] if you

do [want to], here's a notepad.

In the following case, the family member to be interviewed as the internalized

other was not present in the session. The family members who were present included a

mother, Cindy, and her younger daughter, Felicia. Both of them were in therapy over

concerns about Cindy's older daughter, Daphne, who was not present in the session.

Cindy and Felicia described Daphne as having "up and down moods" and expressed fear

that she may injure herself (K. Tomm, personal communication, August 21, 2019).

Upon meeting the clients, Tomm explains to the mother, Cindy, that he will be

interviewing her as her internalized daughter, Daphne, asking her questions and having

her respond from her experience of Daphne's experience that resides within her. After

Cindy and Felicia agree to participate in this "experiment," Tomm further explains to

Cindy: "I might check in with [you] from time to time to see how things are going." This

way of interviewing can lead to clients feeling highly emotional and vulnerable. Tomm's

statement to Cindy underscores his genuine respect and commitment to her well-being, as

he assures her that he will remain intentional, ethical, and ever mindful of the effects of

his interventions.

When interviewing an individual without the internalized other present, Tomm

begins the interview by first asking the person how they feel about him evoking the

internalized other within them in the session. He might ask a question such as, "How do

you feel about me talking to you here in this way?" (K. Tomm, personal communication,

August 15, 2019), which is something he did not historically include in his practice. His

intention in asking this is to create an opportunity to respond to whatever issues the

person may experience in speaking from the experience of the other. This change in Tomm's practice occurred following a presentation he made about IOI. After engaging in an IOI exercise, one participant in Tomm's presentation, who was interviewed as her internalized mother, told Tomm afterwards that it "was a horrible experience" for her. When he asked the participant why this was the case, she stated, "The whole time I was answering in the voice of my mother, I felt like I was betraying her" (K. Tomm, personal communication, August 15, 2019). This led Tomm to realize that there is a difference between interviewing the internalized other as representing the "actual other," and conducting the interview from one's experience of the other's experience. When a participant interprets the interview as a way of answering in the voice of the actual other, it could elicit a sense of betrayal. Thus, Tomm began inviting participants to understand that the internalized other "belongs to them . . . [, that] it may not be the same as the actual other, but . . . belongs to them . . . [,] then they have freedom to speak freely with that voice" (K. Tomm, personal communication, August 15, 2019).

Tomm begins the IOI by asking questions that can be answered simply—for example, by asking clients how they feel about coming to the session. This helps orient them to assume the role of the other. Stepping into another's experience is akin to "entering a culture where the meanings and rituals are somewhat different from your own" (Paré, 2002, p. 25). Thus, starting with small talk and beginning with questions that do not initially involve the other person helps the client "leave his point of view behind and cross over to [his or] her experience" (p. 25). Tomm (1998) asks the person he is speaking with to assume the "I" position of the internalized other, and "to speak from their experience of the innermost experience of the other" (p. 411). He encourages them

to "be as honest and genuine as possible," from their experience of the other's experience

(K. Tomm, personal communication, August 15, 2019).

When clients ask Tomm if the IOI process is similar to a role-play, he states:

I'm asking you not to role play her, not to pretend you're her on the surface, but to

speak from those deeper places you can go within her in terms of saying things

that you intuit is going on inside her, you know, that she may not have ever said

to you, but you think is probably the way she experiences her life. And to try to

speak from that place, realizing that you never know for certain. (K. Tomm,

personal communication, August 15, 2019)

In the following excerpt, Tomm helps clarify the process of the IOI for John—

from the separated couple mentioned earlier—differentiating it from role-play (K. Tomm,

personal communication, August 19, 2019).

KT: Have you had this experience before?

John: No, but it's sort of like role-play.

KT: I'm not asking you to role-play surface behavior that you see, but to enter

into the inner experience of the other and speak from that place. Because the more

you go into your deeper understanding of what's going on in the other person, the

more likely it is we can understand similarities and differences.

KT (addressing John): I'm going to talk to you as if you are [Alice].

Differentiating IOI from role-play helps clarify that IOI is intended to be an

invitation for a person "to speak from his or her experience of the other's experience . . .

from as deeply as he or she is able to enter into the other's experiences" (Tomm, 1999, p.

134). To encourage this, Tomm (1999) invites the person responding as the internalized

other from the position of "I" to "feel free to articulate intuited experiences of the other

that the other person may never have expressed" (p. 134), in congruence with what the

person might feel truly reflects the lived experience of the other.

In the example that follows, Dr. Tomm initiates a conversation about IOI and

role-play, contrasting them as a means of clarifying the intention of the interview. He is

preparing to interview an internalized son, Derek, within his mother, Janice (K. Tomm,

personal communication, August 20, 2019).

> KT (to Janice): While I'm talking to you, [Janice], I'm going to talk to you as if
>
> you were [Derek] and I want you to answer, not through role-playing him, not his
>
> outside surface behavior, but from as deep inside him as you can go, realizing you
>
> don't know for sure, but giving it your best intuitive guess about what his inner
>
> experience is like.

As Tomm addresses the person embodying the internalized other, he asks

questions of that person as if they were the actual other, using the name of the

internalized other repeatedly, enabling the process, and "grounding her again and again,

in her experience of [the other's] experience" (K. Tomm, personal communication,

August 15, 2019). Tomm explains his personal process by stating, "Sometimes I actually

try to visually hallucinate the internalized other as a way to ground myself into speaking

to [that internalized other]" (K. Tomm, personal communication, August 15, 2019).

As the process continues, Tomm asks the internalized other to identify something

that they appreciate about the person being interviewed, thereby "opening space for [the

person's] own knowledge and also the positive feelings associated with that knowledge to

emerge" (Bubenzer et al., 1997, p. 90). Asking about the person's positive qualities,

about what they appreciate, admire, or feel proud of in the other, helps create a positive emotional climate. Tomm points out, however, that this question can sometimes be a difficult one for clients to answer.

Tomm consulted with a primary therapist on a case involving a mother and father with their son and daughter. This was the fifth session for this family. The parents were separated 11 years prior to the session, and the father lived in a separate household. The focus of the therapy had been on developing strategies for reconnecting the siblings, which had been somewhat successful. Another goal of therapy, which had been less successful, was improving the relationship between the father, Bruce, and the 15-year-old son, Michael (K. Tomm, personal communication, August 22, 2019).

The following example demonstrates the difficulty that this question can pose for the person being interviewed. After Bruce responded to Tomm's question about Michael's positive qualities, Tomm chose to ask the question in a different way, using a temporal difference question to generate a different response. In the following excerpt, Tomm interviews Bruce about the internalized son, Michael, within him.

KT (to Bruce): [Michael], what about Dad do you appreciate the most?

Bruce: I don't appreciate anything.

KT: Think about him and what you admire. Go back to before last year. What positive moments do you remember?

Bruce: Baseball, Rockies, trips.

KT: What happened during those times that made you feel good about him?

Bruce: [The] special one-to-one connection [we had].

The following transcript offers another example of the difficulty clients can experience when attempting to answer this question. Here, Tomm works with Derek and his mother, Janice, to reorient the question by recontextualizing it and then rephrasing it (K. Tomm, personal communication, August 20, 2019).

KT (to Janice): [Derek], what would you say that you can honestly appreciate the most about your mother as a person? [What would you say are her] special talents, [her] gifts, as a person in the world?

(Janice struggled to answer)

KT: If you, [Derek, were] . . . with a group of friends, talking about mothers and boasting about mothers, and it was your turn to boast about [your] mother, what would you say, [Derek]?

Janice: [Well, the] times when [we] can talk openly.

KT: I still want to get your take on your mom as a person. What can you honestly say you appreciate about her as a person?

Janice: That she cares.

KT: How does she show caring? What does she do or say?

Janice: She tells me that she loves me.

KT: How else does she show [that she loves you]?

Janice: [She] offers to do things with me, [and she] take[s] me places. I don't always want to do it.

KT: So, she's generous with her time.

When working with a couple, the therapist can extend the question to ask the internalized other about positive aspects of the relationship (Lysack, 2002). In the

following transcript, Tomm interviews the internalized Alice within John. One noteable feature of the transcript is Tomm's refocusing of the internalized Alice, so that she is responding about her relationship with John instead of speaking about him as an individual or a father (K. Tomm, personal communication, August 19, 2019).

KT (To John): Let's talk about the present. What's happening now in your relationship that you value, feel good about, want to preserve, and don't want [your therapist] or me to mess with?

John (speaking from his internalized Alice): A good dad for [our young son].

KT: So, he's committed to your son's growth and development as well as you; but in terms of your relationship with [John] at this moment, what do you see you still have in that relationship that's meaningful to you and you value? Something like honesty or openness or anything that you still value there?

John: Probably friendship.

KT: So, you have some friendship. Anything else[, Alice]?

In the following dialogue, Tomm asks the internalized daughter, Daphne, within her mother, Cindy, about the positive qualities in their relationship. This transcript demonstrates Tomm's way of asking the internalized other about their relationship with the other person, the actual other, when that individual is not in the room. In this case, Daphne, the actual other, is not present (K. Tomm, personal communication, August 21, 2019).

KT (to Cindy): In the relationship you have with your mom now, [Daphne,] what in the relationship do you want to keep that you value? That you hold? That you want to grow a bit?

Cindy: [The] friendship [I have] with Mom.

KT: What else?

Cindy: For love to grow.

The following excerpt comes from Tomm's interview with the internalized son, Derek, within his mother, Janice. He demonstrates the process of providing context to foster her response to this question, which tends to be difficult for clients to answer. He begins by making reference to a goal Derek previously identified for this session (K. Tomm, personal communication, August 20, 2019).

KT (addressing Janice): [Derek], you mentioned earlier . . . [the] thing[, the] best place to work . . . [, is on the] relationship with Mom. What change would be most meaningful to you? [This is] not an easy question. Take your time.

(Janice does not respond for a few seconds)

KT: Let me ask you an easier one. What do you appreciate[, Derek,] about the relationship you already have with your mom and you want to continue? You want to leave in place and don't want [your therapist] or I to mess with that? That you value and want to keep as part of your relationship, [Derek]?

Janice: Trust and security.

KT: [So, in your relationship with mom, what you want to hold onto is the] trust and sense of security. And that means a lot to you. You don't want us to mess with that. You want to keep it and maybe even strengthen it? Or would you like to loosen that connection with your mom?

Janice: [I] want to loosen it somewhat. But have her still.

Tomm then directs his questioning toward asking about the relationship between Derek and Janice and about the issues the internalized other is experiencing in the relationship. This series of reflexive questions, directed toward the internalized other, includes questions about concerns this individual has regarding themselves, the actual person being interviewed, the interaction that exists between them, their relationships with other family members, and their social and cultural context (Tomm, 1998b).

In the following transcript, Tomm continues his interview of the internalized Alice within John, illustrating his use of reflexive questions that ask about the aforementioned concerns (K. Tomm, personal communication, August 19, 2019).

KT: What is it about your relationship with John now that worries you the most?

John (speaking from his internalized Alice): He's not kind to me.

KT: How would you describe it then? If not kind, what is he?

John: Disengaged from me.

KT: So, sort of disconnected. Distant. And that bothers you. Is that because you want to continue in the relationship you had with him? To go back to that? You're missing that?

John: I think there's some part of that.

KT: So you're having trouble letting go?

John: [Yes, some] unresolved issues preventing letting go.

KT: Are you willing to share the unresolved issues?

John: [I] feel he didn't give me a chance in the relationship.

KT: So, back to [the] unresolved issue . . . . [You] feel you can't let go because he didn't try enough? Would you say you're beginning to move on . . . and letting

that go now? [It's] been over a year.

John: [Yes, there are] moments. Yes and no.

In seeking to understand Michael's feelings about his relationship with his father, Bruce, Tomm asks the internalized Michael within Bruce about his concerns (K. Tomm, personal communication, August 22, 2019).

KT: What troubles you most about your relationship with your dad[, Michael]?

Bruce: He gives me a hard time.

KT: You miss having that one-to-one connection with him? Deep down inside your heart?

Bruce: Yes.

In the following example, Tomm explores the concerns that Daphne, the internalized other, has about her relationship with her mother, Cindy. It also demonstrates Tomm's use of apology and forgiveness, an important aspect of his clinical work which was previously described in Chapter VI (K. Tomm, personal communication, August 21, 2019).

KT: At this moment, [Daphne,] what are you most worried about in your relationship with mom?

Cindy: When [I was] young, she beat me, and I can't trust her.

KT: Have you experienced your mom feeling regret? Or [has she] apologized? What is it like for you to experience her apology?

Cindy: [It gives me a] sense of comfort.

KT: Have you felt any forgiveness toward mom for hurting you when you were younger? Do you think your mother can forgive you for not being ready to forgive

her?

(Cindy starts crying)

KT: [Daphne], is that your sadness or [Cindy]'s sadness coming up? [Daphne], do you ever share sadness together? Cry together?

(Cindy continues to cry)

KT: Is it ok for me to continue in this? I know it's hard.

Cindy: [Yes], continue please.

As this process continues, Tomm asks the internalized other what they would appreciate most if the person being interviewed were willing and able to make some changes. He then explores with the person how such changes might be enacted. This serves as an invitation to the person being interviewed to look at themselves critically through the eyes of the internalized other, "and to hold himself accountable, . . . which is a useful application of . . . healthy guilt" (K. Tomm, personal communication, August 15, 2019). These questions invite the person being interviewed "to listen to her listening, to hear how she hears . . . and to experience [the internalized other's] experience more fully" (Tomm, 1998b, p. 411).

In the following transcript, Tomm asks the internalized Alice within John what changes she would most appreciate. As Tomm listens to the internalized Alice's responses, he asks other questions to assess her safety, explore her position in the relationship, and gain a better understanding of the issues related to dominance and the hierarchy that have been established. These questions are intended to have John begin imagining what Alice's experience is and may have been—to have John enter into a

broader and deeper understanding of her experience in their relationship (K. Tomm, personal communication, August 19, 2019).

> KT: If [John] were willing and able to make some changes right now in the way in which he responds to you or deals with the situation with your family, what single change would you appreciate the most, [Alice]? If [John] were willing to make a change?
>
> John: Treating me with kindness and slowing things down.
>
> KT: If he was treating you with kindness, what would he be doing differently?
>
> John: [He'd] speak in a softer voice, have more patience, giv[e] me more time to think about things.
>
> KT: You experience John pushing you[, Alice]? In what ways?
>
> John: When we disagree, he can push pretty hard. He becomes cold. Doesn't stop.
>
> KT: He persists? Pressures you?
>
> John: [He] persists and puts pressure.
>
> KT: Do you get afraid when that happens? For your safety?
>
> John: No. I get angry
>
> KT: Because he wants you to adopt his perspective? Or he's not listening to you? Or what?
>
> John: He's trying to control the situation
>
> KT: So, you have the experience he's trying to control.
>
> John: He's trying to control.
>
> KT: What's it like for you inside when he's trying to control?
>
> John: [I feel] backed up against the wall.

KT: What's that like emotionally for you?

John: I get panicked.

KT: When you get panicked like that, what do you tend to do?

John: I get angry.

KT: [Do you] show [it] openly? Keep it inside?

John: Openly. Yelling. Digging in heels.

KT: [John] listens to you? When you yell? Those moments when you're angry, what do you think is underneath the anger? If you dig deep inside yourself?

John: Inability to control. Or feeling lack of control.

KT: So, control is a big issue here for you. Let's go back to the earlier question.

In the next dialogue, Tomm asks this question to the internalized daughter, Daphne, within her mother, Cindy, when Daphne is not present. It also demonstrates Tomm's use of positive connotation (K. Tomm, personal communication, August 21, 2019).

KT: [Daphne], if your mom were willing and able to make a change in how she relates to you right now, what change would you appreciate the most?

Cindy: [For her to] show her love—express her love.

KT: What can your mom do to show the love for you?

Cindy: [I want to] hear [it] in words.

KT: Where would the best place for this to happen?

Cindy: Anywhere.

KT: So, let's imagine your mom was willing to do more than that, what other changes [would you appreciate her making, Daphne]?

Cindy: [To] believe I can do things right.

KT: Maybe it's her worries about you rather than not believing in you?

Cindy: [Well,] she worries too much.

KT: So, you want her to worry less about you. What other things [can] your mom.
. . say or do to change the way she's a mother to you, [in addition to her]
speak[ing] her words of love, letting you know she has confidence in you?

Cindy: [To] accept me as I am.

Tomm follows this exchange by asking questions that home in more specifically on how
such changes in the relationship might be enacted.

In the next excerpt, Tomm asks the internalized son, Derek, within his mother,
Janice, about this change (K. Tomm, personal communication, August 20, 2019).

KT: [Derek], if your mom could make a change in the way in which she treats
you, or talks to you, or relates to you, what single change would you appreciate
the most, [Derek]?

Janice: Respect. Treating me more like [an] adult.

KT: If your mom were to make a more concerted effort to show you more respect,
what would she be doing or saying to you that she's not doing or saying now?

Janice: [She'd give me] more praising for little things.

KT: Acknowledging things you do—to show respect. What else?

Janice: Talking more respectfully. Not getting down to my level and staying the
adult.

KT: So that she [can] find a way to deal with irritation and not let it take over?
What other changes besides showing more respect, less irritation . . . what else?.

Parts of this interview process simulate the process of identifying interpersonal patterns. For example, asking a question about what changes might be made can be a way of addressing possibilities for developing a healthy interpersonal pattern (HIP). The therapist may also ask the internalized other a question such as, "What concerns do you have about the interviewee as a person and/or about [your] relationship with the actual other?," to discover and attempt to establish a pathologizing interpersonal pattern (PIP) (K. Tomm, personal communication, August 15, 2019).

An example of this can be observed in the case of the father, Bruce, and his son, Michael, in the ensuing dialogue. Here, Tomm brings forth a recurrent PIP, in which Bruce, criticizing Michael and being repeatedly disappointed in him, results in Michael feeling judged and criticized. This then results in Michael becoming self-critical and disappointed in himself, thereby decreasing his motivation to pursue his goals and adding to the impasse in their relationship (K. Tomm, personal communication, August 22, 2019).

> Bruce (speaking about Michael): [He] stopped trying [in] everything. [With his] learner's permit, baseball. [He's] only watching videos.
>
> KT: Disappointment being your reaction again and again

There was an additional PIP demonstrated in this case, which Bruce noted and acknowledged at the end of the session: The feelings of fear and helplessness that Bruce experiences when he goes without seeing his son for extended periods of time lead him to protect his vulnerability and avoid sharing his feelings with his son.

After identifying a PIP like this one, the therapist would ask the internalized other if there are any questions they want the therapist to ask to better understand their

relationship. This important meta-question about the interviewing process tends to produce new avenues for discovery and exploration (Bubenzer et al., 1997), as seen in the following transcript of Tomm interviewing John's internalized Alice (K. Tomm, personal communication, August 19, 2019).

> KT: Are there other things we haven't talked about to help me understand more about your relationship?
>
> John: His interaction with our oldest son.
>
> KT: What kinds of changes do you want to see there?
>
> John: [I want to] leave any issues with [our] younger son away from [the] oldest son. [I'm] still hurt over my perception of how he treated our oldest son as he grew up—still issues that hurt me.
>
> KT: Do you think he owes [him] an apology? [Do you] think he's come into [an] awareness of [the] potential value of that apology? Do you feel [John] means well, with respect to care for you being the mother of his sons? Or [do you think he] carries malice and is, in a sense, out to hurt you? What's your experience?
>
> John: He means well but can be quite distant and cold.

Post-Interview Processing and De-Briefing

Following the interview, processing begins in the form of questions. Tomm may begin by asking the person he is interviewing to "describe their experience of being interviewed in this way" (Lysack, 2002, p. 235). For example, he may ask the person to estimate "what percentage of their internalized-other responses they think they got correct" (Bubenzer et al., 1997, p. 94). In essence, this question is aimed at having the person assess the degree to which their answers were congruent with how the actual other

might have responded. It promotes the person to reflect on the idea that how they envision and experience the other's experiences is essentially a set of assumptions (Bubenzer et al., 1997).

At the end of the IOI with John's internalized Alice, Tomm, assists John in reorienting back to himself or, in other words, saying goodbye to Alice and hello to John. He continues to help refocus John back to himself by asking him about the experience of being interviewed as Alice (K. Tomm, personal communication, August 19, 2019).

KT (to John): So, what was the experience like? Easier than you thought? Harder?

John: It was pretty easy.

Tomm then asks John a scaling question about how immersed he felt he was in Alice's experience (K. Tomm, personal communication, August 19, 2019).

KT: [On a] scale [of] zero to 10, with zero being [you were] not into [her] psychological space and 10, [you were] totally there.

John: Three.

KT: What percentage of answers as [Alice] do you imagine she'd resonate with?

John: Fifty percent.

KT (to Alice): Your perception?

Alice: 10% (K. Tomm, personal communication, August 19, 2019).

Following the IOI, Tomm frequently uses scaling questions that range from zero to 10, to bring forth "how far [people are] able to get into the experience of the other" (K. Tomm, personal communication, April 23, 2020). If the client responds with a number higher up on the scale (for example, seven or eight), it indicates that there is room for

more. Accordingly, Tomm finds it useful "to lead people with that orientation" (K. Tomm, personal communication, April 23, 2020). Conversely, if the client responds with a low number, such as a one or a two, Tomm considers this to be information about how much the person knows about their partner; it "becomes an invitation for them to become more other-focused around the center" (K. Tomm, personal communication, April 23, 2020).

In the following transcript, Tomm poses a question to Bruce, after he has been interviewed as his internalized son, Michael. Tomm then solicits the perspectives of the other family members who witnessed the interview. He intentionally turns toward Michael, asking him about the degree of resonance he experienced between his father's experience of his experience, and his own personal experience as his father's son (K. Tomm, personal communication, August 22, 2019).

> KT (addressing Bruce): [What's your] honest guess about [the] percentage of your answers Michael could resonate with—what fits for him?
>
> Bruce: Sixty to seventy percent.
>
> KT (addressing Michael's sister): How much do you think your dad understands Michael? What [do you think] is the fit for your brother?
>
> Daughter: Ninety percent.
>
> KT (asking same question to the mother)
>
> Mother: Thirty percent.
>
> KT: (asking same question to Michael)
>
> Michael: Thirty percent.

When working in the presence of the other, asking about the percentage of resonance serves to reveal how much consistency or discrepancy there is. This information can then be used therapeutically. The processing can then become more detailed and specific, generally beginning with questions directed toward the actual other and focusing, at first, on what is positive (Bubenzer et al., 1997). In the following excerpt, Tomm asks Alice, the actual other, who has just observed herself being interviewed within John, about the positive aspect of the degree of resonance she identified (K. Tomm, personal communication, August 19, 2019).

KT (to Alice): Really? What about the ten percent fit for you?

Alice: Him being a good father with our younger son, but he was absent for him.

The following brief exchange shows Tomm asking Michael this question after he witnessed the interview of himself as the internalized son within his father, Bruce (K. Tomm, personal communication, August 22, 2019).

KT: (to Michael): In that thirty percent [that you think your Dad got], what fit for you?

Michael: [The] memorable things we did together.

As illustrated in the excerpts above and below, the question, directed to the actual other who was listening to the interview, is intended to ascertain "how close the answers of the 'internalized other' would be to her actual answers" (Lysack, 2002, p. 235). It also serves to illuminate what, if anything, was new to them, "highlighting those answers . . . most pleasing . . . to hear" (p. 235). The therapist can use the percentages that clients give to formulate follow-up questions, such as, *In the 75% that you were in agreement about, was there something spoken about that surprised you?* This process of addressing what

surprised the person about what the other knew about their experience can sometimes be "the most significant part of the whole process[,] . . . the realization that the person knows the other individual so well" (Bubenzer et al., 1997, p. 94).

In the dialogue that follows, Tomm asks Derek about the 70% his mother, Janice, believed resonated with him. Most notable in the following example is how Tomm seeks to bring forth differences, even though Derek has identified a high degree of resonance (K. Tomm, personal communication, August 20, 2019).

> KT (to Derek): In the seventy percent that [your mom says] fit, were there any answers that [she] gave [as you] that . . . surprised [you]—that she could do that well?
>
> Derek: Yes. How she was more understanding about me and [the one about her thinking she could] act more like a parent.

Questions like these are aimed at creating space to discuss differences. When Tomm engages in IOI, he prepares for this part of the questioning by extending to the person "an invitation for them to become ready, to become interested in hearing" (Bubenzer et al., 1997, p. 94). This primes the person and fosters curiosity about hearing the ensuing discussion (Bubenzer et al., 1997), as demonstrated below in Tomm's post-session conversation with John and Alice (K. Tomm, personal communication, August 19, 2019).

> KT: [John], are you comfortable with [Alice] sharing the ninety percent that didn't fit [for her]? (Addressing Alice) [What are the] main things you'd like him to understand?

Alice: One thing he did do to [our oldest son is, he] apologized. But not to me. (Speaking directly to John) You scarred him. Because he came out gay. You were absent when he came out. That hurt him.

Following the discussion about the amount of resonance (for example, 70%), the therapist then asks the person if they would like to hear more about what did not resonate (for example, the 30%) (Emmerson-Whyte, 2010). The line of questioning that ensues is designed to explore the "effects of this new knowledge with the actual person" (Lysack, 2002, p. 236). The therapist might ask, for example, "What difference does this make for you to know that [he] understood that about you?" (p. 236). From here, the therapist can explore with the person how this new knowledge might generate different responses. This might include asking about what one individual believed the other missed, such as, "'What aspects of the issues he missed would you like your son to know more about?'" (Bubenzer et al., p. 94). In this example, the question invites the parent to be more forthcoming and descriptive, allowing further development of the internalized other to surface.

In the dialogue that follows, Tomm asks questions to further explore the effects of this new knowledge for the actual person, who, in this case, is the son, Michael (K. Tomm, personal communication, August 22, 2019).

KT: (directed toward the father, Bruce): Are you interested in hearing about the seventy percent that didn't fit [for Michael]?

(Before Bruce responds, Michael interjects)

Michael: The approach—so aggressive.

KT (directed toward Bruce): Do you hear what he's saying about your experience of his experience of you? What are you hearing that is a difference? What is it he is saying that would make a difference?

Bruce: [For me] to try being less aggressive.

KT (directed toward Michael): What else?

Michael: Mom is hurting.

After the IOI of the internalized Michael within his father, Bruce, Tomm invites Michael to be interviewed as his internalized father. In the post-session, Tomm asks the family members about the degree of resonance Michael's answers had with the father's lived experience. The father's response is "seventy to seventy-five percent." The dialogue continues as follows (K. Tomm, personal communication, August 22, 2019).

KT (to the father): Is there anything in that seventy to seventy-five percent that fit that surprised you? That he understood about your experience?

Bruce: No.

KT: Of the answers that fit for you, which did you appreciate the most?

Bruce: [Us spending] more time together, [doing] activities together.

KT: (to son, Michael) Are you interested in hearing about the twenty-five to thirty percent of things that didn't fit with dad?

(Bruce interjects)

Bruce: [Michael's] not anxious to come here. [He] just wants results.

KT: (to Michael): [Do] you feel more positive than he thinks [you do]? Are you surprised to hear this?

Michael: Yes.

Bruce: [I'm] not in touch with my fear about him. When I don't see him for a long time.

KT (to Bruce): Why doesn't he see this in you? [Do] you mask it somehow? What do you imagine might happen if you were more honest and open about how scary it is for you as a father?

Bruce: [I] don't want to feel vulnerable—would never express that.

KT: What's wrong with being vulnerable?

Bruce: [You] gotta be the strong one as a parent. Right?

KT: If the relationship is strong, then one needs to be weak. Vulnerability creates more intimacy and connection; we feel closer to people when we are more open and honest with them.

Bruce: Guilty as charged. [I] was really hurt once.

The following excerpt illustrates how the conversation about the IOI can bring forth deeper understanding and open space for significant change. Exploring the effects of the new knowledge that emerges can elicit different responses. In the next excerpt, taken from the post-session of Tomm's IOI with John and Alice, Tomm begins by asking Alice about the effects of John's actions on her (K. Tomm, personal communication, August 19, 2019).

KT: So, these are new things he didn't bring up. But of the ninety percent of things he *did* bring up that missed the mark, what would you like him to understand that he doesn't understand?

Alice: The hurt.

KT: He said that.

Alice: He cheated on me, blamed me for everything. I carried the load . . .

KT: So, [it was the] *degree* of hurt you suffered is what he doesn't get.

KT (to John): What are you understanding now, as a difference between your sense of her experience and what she's trying to convey now? Do you understand the difference? 'Cause she [is] trying to help you understand she's experienced something different than what you imagined she's experienced. What do you see as the difference she's experiencing now?

John: It's the magnitude.

KT (to Alice): Is that the main issue? The magnitude?

Alice: No. He truly doesn't understand what he did. He broke our family up. [And] hurt me on top of it.

KT: Are you saying he doesn't appreciate how bitter you are?

Alice: I'm hurt more than bitter. He doesn't acknowledge it.

KT: I'm hearing bitterness too. (To John): Are you hearing bitterness?

John: Yes

Alice: Sorry!

KT: It's a common reaction. But obviously this is something you can't let go.

Alice: I'm trying.

KT (to Alice): What is it you need to let go?

Alice: That it's all my fault.

KT (to John): Do you think it's legitimate for her to let go of this idea? She has, for whatever reason, [been] feeling it's all her fault. Do you think that's an unrealistic view? That maybe she should relinquish the idea?

John: She should. We covered this. We said it's not all her fault.

KT: Can you help her by being more clear of what part you own so that she doesn't continue to carry that distortion?

John: She's talking about a point in time . . .[I] gave [her] a list . . . [of] 30 things . . . . If she could fix 30 things. We went to therapy. She worked really hard.

(Alice begins crying)

John: It wasn't the 30 things I was unhappy with. I completely missed the mark. It wasn't her fault. Her and I were too different. It was seeing her contort herself to changing those 30 things. It wasn't her. It was me.

KT: Can you say that to her?

John (to Alice): It wasn't you. I was asking you to do something that was completely unfair.

KT: Say it again. Louder.

John: I was asking you to do something completely unfair.

KT: And it wasn't you.

John: It wasn't you. It was me.

KT (to Alice): What's he saying?

Alice: [He's] sorry! (Alice is now sobbing)

KT: No. It's ok. It's important. Very important. Can you accept what he's saying?

Alice: Yeah.

KT: Good. Good for you. You must appreciate him being willing to speak those words to you.

Alice: Yeah. Thank you. (To John): Thank you.

KT: Obviously, these are very important words for you and for you. To be able to take them in and accept them and allow them to influence your reality is very useful. And we appreciate you being open to that.

Alice: I wanted that for so long.

KT (to John): [Is there] anything else you'd like to add? Sounds like it was very meaningful for her.

John: The reality of what I wanted.

KT (to Alice): Wait. When [I was] interviewing the internalized [Alice] in him, she wanted more kindness. Isn't that what *you* want?

Alice: What I want most is respect. As a person. As the mother of his children.

KT: Is there anything he said today that does convey respect?

Alice: What he did now. The acknowledgment.

KT: Taking responsibility. And the other thing—he realized the 30 things. You tried hard to make the changes. [He] implied and conveyed some respect for your efforts. Did you feel that? Do you want to ask him?

KT (To John): Can you say this to her?

John: Yes, I respect her for her efforts and [for]the results. And what made me particularly happy [is] when [you were] doing those things for yourself. Not me. [Those] self-actualizing things. [I have a] lot of respect for that. When you go to school. When you put effort into [our] younger son. [I have] a lot of respect for you when you put [in] effort. You're completely capable of doing whatever you put your mind to.

KT (to Alice): Can you accept that?

Alice: Yes.

KT: Good. Great to hear that.

A consideration when the internalized other is not present is that it becomes more difficult for the interviewee, as there is the tendency to perceive the experiences of the internalized other as factual. For this reason, it is important to ask the interviewee, "'What percentage of your internalized-other responses do you think the other person would agree with?'" (Bubenzer et al., 1997, p. 94). To those who respond with a high percentage, the therapist might then ask, "'Would you be surprised if they only agreed with you 50% of the time?'" (p. 94). This serves to invite the interviewee to be less definitive, instead becoming more curious about the actual other and looking "to discover more about where the other is coming from" (p. 94).

In the ensuing dialogue, Tomm asks the family members in the room these percentage-based questions about the actual other—the internalized other who is not present in the session— who, in this case, was Daphne (K. Tomm, personal communication, August 21, 2019).

KT (to Cindy, the mother): What's your honest guess about what percentage of your answers as [Daphne] do you think: "that's probably how she feels", or "no, it's different"?

Cindy: Eighty percent.

KT (directed question to Felicia, the sister): What percentage [do you think] would fit for [Daphne]?

Felicia: Seventy percent.

KT (to Felicia): Do you have a hunch at what part of that thirty percent do[es]n't agree?

Felicia: [Mom] understanding her.

Cindy: [For me] to be less judgmental, more aware of what I say.

Possible Effects

The possible effects of this practice are numerous, potentially affecting the one responding to the interview questions, the one listening, and the relationship itself. When it comes to the issue of responsibility, Tomm (1999) has discovered that when a person responds from the "embodied experience of the other as internalized within the self" (p. 134), a shift occurs regarding their awareness about the effects of particular interactions. He describes this process as "an invitation to move into the 'intersubjective' space" (Tomm, 1999, p. 134). By asking the internalized other questions about the effects of their actions, the therapist opens space for the person, to distinguish, with increased awareness, between the actual effects and the intended effects of their actions. Such questions might include, "'What did it feel like for you, (name of the internalized other), when (name of the self) did . . .?' . . . 'Which of those feelings did you disclose and which did you keep inside?' 'What held you back from revealing more . . . ?'" (p. 134).

In his experiences with clients, Burnham (2000) has observed that the process of IOI "facilitate[s] understanding, change and development of ideas, emotions, behaviour and relationships" (p. 16). Speaking about their experience of responding as the internalized other, clients frequently reported the experience "as 'like I was in their shoes', or 'inside their skin'" (Burnham, 2006, p. 32). Burnham notes that this way of interviewing provides both people with improved ways of moving on and making

changes in their relationships. Stimulating curiosity and generating empathy for the internalized other's experience helps foster "a shift from self-centeredness toward other-centeredness" (Tomm, 2007, slide 21), thereby opening space for changes in behavior. This particular effect of the IOI is evident in the case of John and Alice, as John acknowledged how his actions affected Alice, assumed responsibility for those actions, and expressed respect for Alice's experience, resiliency, and motherhood. The feedback exchanged in the de-briefing portion of the interview presents an opportunity to correct misguided beliefs the actual other had regarding their internalized other. With "the imagined appreciation of the other" (Tomm, 2007, slide 21), the actual other can develop greater self-esteem and experience a sense of freedom. This creates the opportunity for influencing the other in positive ways and altering those internalized relationships that were previously maintained (slide 21).

The actual other, who observes quietly and listens without having to respond in the moment, has the opportunity to reflect on the experience and entertain possible meanings. As the respondent becomes more aware, the listener also gains awareness of their own experience, as well as of "the respondent's understanding of one's own experience and/or the lack thereof" (Tomm, 2007, slide 22). Listening to the respondent's internalized other, the listener is given an opportunity to generate possible change in their *distributed self*. When IOI is used conjointly, a "dual process of interviewing" takes place; (K. Tomm, personal communication, April 20, 2020); there is the interview of the internalized other, as well as the interview of the distributed self, as the observer sees themselves distributed in the other. Tomm refers to this as a "process of enhanced understanding" (K. Tomm, personal communication, April 20, 2020), which has the

effect of "deepening the sort of empathic understanding of the person you're speaking to by speaking to their internalized other" (K. Tomm, personal communication, April 20, 2020). This new understanding of the other, and of oneself within the relationship, allows the person to "gain access to some intuitive knowledge they already had, but they didn't know that they had . . . a co constructing of awareness of . . . how we come to understand ourselves and the other in our relationships" (K. Tomm, personal communication, April 20, 2020).

In terms of prospective effects in the relationship, the people in session can reflect on experiences and occurrences from the past that may have influenced their current interactional patterns. This assists in the process of deconstructing pathologizing patterns and co-constructing patterns that foster wellness. The opportunity to assume responsibility can mitigate conflict in the relationship, shifting "the energy from outer criticism toward holding oneself accountable" (Tomm, 2007, slide 23). As clients listen and participate in the interview, they become "an appreciative audience" for one another, "foster[ing] mutual appreciation and respect" (Tomm, 2007, slide 23). According to Lysack (2002), clients have described the effects of IOI "as gentle and non-intrusive, and yet, at the same time, powerful and transformative" (p. 221). Reflecting on the practice of IOI, Emmerson-Whyte (2010) shares Epston's sentiment that "it has people listen 'as though their life depended on it;' and people's selfhood and identities in large part actually do" (p. 19).

Key Elements

Referring to the indications for deciding when and for what purpose to use IOI, Tomm describes how he ascertains when to use it—as "an opening, as a . . . possibility to

take things further, when I come to maybe a little bit of a knot . . . in terms of persons'

understanding, or relationship" (K. Tomm personal communication, April 20, 2020). The

IOI approach is particularly useful for clients who have a genuine desire to "make

changes in themselves in [their] relationship to [a] significant other" (K. Tomm, personal

communication, April 20, 2020). It is also helpful for clients who are considered to have

been "highly therapized" (K. Tomm, personal communication, April 20, 2020), as they

might have a tendency to respond how they believe their therapist wants them to, thereby

engaging inauthentically in the therapeutic relationship. In these cases, a key benefit of

IOI is the bypassing of defense mechanisms, an issue that I will further explore later in

this chapter.

      Tomm delineates a number of important elements of the internalized other

interview for therapists to attend to: (1) careful listening to both the person being

interviewed as they share their own experience, and to their elucidation of the

internalized other's experience; (2) consideration of the common family interaction

patterns to inform a therapeutic response; (3) identification of cultural patterns; (4)

identification of pathologizing patterns; (5) a line of questions that deconstructs

pathologizing patterns to permit the bringing forth of healing patterns; (6) use of reflexive

questions (Tomm, 1998b). As a practice and method of questioning, IOI "encourages the

person to adopt a second order perspective on their relationships with others" (Tomm,

1998b, p. 411). Tomm (1998b) views himself:

      working in the areas of overlap among interaction patterns within family members

      (which have a history and tend to be enduring), between family members (which

      tend to be transient unless supported by internalized patterns), and between family

members and their cultural context (which can be very powerful in maintaining

individual and family patterns). (p. 412)

The process of entering into and remaining in the internalized other's experience

can be challenging. Tomm notes that this is related to "our individualism[, in which]

we've been socialized into being individualistic" (K. Tomm, personal communication,

August 15, 2019). In contrast to those with European Western cultural backgrounds,

Tomm's practice is informed by his experience working with First Nations people, who "

have much greater ease . . . entering into speaking [from] the experience of the other

[and] often will tell you . . . if . . . asked a question, . . . they have to confer with their

community[,] . . . with the elders" (K. Tomm, personal communication, August 15,

2019). Language is another significant contribution to a person's way of being, and the

words used in certain cultures—such as First Nations—tend more toward relational ways

of being. Tomm points out that in the West, we tend to "favor individualistic ways of

thinking, and we're caught in that by virtue of drifting in language for so long" (K.

Tomm, personal communication, August 15, 2019).

How a therapist chooses the person in the dyad to interview can depend upon

different factors. Generally, the therapist allows the people in the session to choose who

will be interviewed first. However, when it becomes apparent that one person in the dyad

presents as a dominant partner, Tomm will select that person to be interviewed "as a way

to invite them into a bit more humility with respect to how difficult it is to enter into and

speak from the experience of the internalized other" (K. Tomm, personal communication,

August 15, 2019). In such cases, there may be only one interview, based on the

therapist's determination as to what will be most therapeutic. This was the case with John

and Alice, the separated couple who was in therapy for the goal of co-parenting their two sons. Tomm chose to invite John to be interviewed as his internalized Alice.

Tomm describes a "spectrum between . . . two poles, where people are . . . self-centered or other-centered" (K. Tomm, personal communication, April 20, 2020). For those who are self-centered, IOI can be a way to shift away from this tendency toward becoming "more grounded in her experience, and centered in her experience more fully" (K. Tomm, personal communication, April 20, 2020). In situations involving abuse or violence, Tomm interviews "the internalized person who has been abused within the perpetrator of the abuse" (K. Tomm, personal communication, April 20, 2020). This serves as a way to invite the perpetrator into more awareness of the abused person's experience—"to have that experience available to him as a restraint" (K. Tomm, personal communication, April 20, 2020). This process allows perpetrators to enter into a new understanding of their partners' experience, of which they were previously unaware. With this new understanding, they have an opportunity to make different choices regarding the relationship, and "grow on that continuum from being self-centered to being more other-centered" (K. Tomm, personal communication, April 20, 2020).

Tomm explains that he has been asked in the past about whether IOI is trance-like, to which he responds that while he does not conceptualize IOI in terms of hypnosis, it "could be an induction process" (K. Tomm, personal communication, August 15, 2019). His rationale for not using the metaphor of trance is, in part, due to his not wanting "to sort of plant any hypnotic suggestions" (K. Tomm, personal communication, April 20, 2020), choosing instead to "privilege more conscious awareness . . . [,] more

understanding, consciously, . . . [so that] that's the preferred outcome in terms of the

potential resource" (K. Tomm, personal communication, April 20, 2020).

In 1997, Tomm identified a hope for the use of IOI in the future. He envisioned

creating change that would "contribute to a social reconstruction of [the] internalized

other to be a more therapeutic or healing or wellness resource for the self" (Bubenzer,

1997, p. 92). An example of this might be reconstructing a person who is not present as

the one "willing to make a change or to reconcile with a client" (p. 92). The key element

here is the idea of co-constructing an IO who is "willing to reconcile" (p. 92), regardless

of whether or not the actual person is willing. This can create a change in the relationship

that the person has with the actual other, as they "become more like the 'reconciled

internalized other' of the client" (p. 92). Tomm demonstrated this phenomenon in an

interview with a woman's internalized child, whom she had given up for adoption, in

which he invited the woman to "experience herself through the eyes of the child" (K.

Tomm, personal communication, April 20, 2020). With this client, he used IOI as "a way

of constructing realities . . . to generate more reality . . . not arbitrary realities" (K.

Tomm, personal communication, April 20, 2020).

Variations in Technique and Possibilities

The practice of IOI is possible due to "a fundamental phenomenon in human

relational dynamics[, having] to do with the nervous system developing to the point of

plasticity that it can retain memory . . . of past transactions" (K. Tomm, personal

communication, August 15, 2019). In our interactions with one another, we become part

of each other. Others become internalized within us, becoming part of our sense of self.

The flexibility of our nervous systems enables us to be "flexible and creative" (K. Tomm,

personal communication, August 15, 2020); therefore, we can apply this practice in various and limitless ways to address different issues. In exploring racism, someone from a dominant culture can be interviewed with the questions directed to a person of color, the internalized other within the actual other (K. Tomm, personal communication, August 15, 2020). It can be used to help parents develop greater empathy toward their children, to assist adults with entering more deeply into the experience of their ailing aging parents, or to help adolescents better understand another's perspectives within a conflictual relationship (Burnham, 2000; Paré, 2002).

More than one internalized other can be interviewed within the same person, according to Tomm (Bubenzer et al., 1997). For example, one might be interviewing a son and his internalized father, and then interview his internalized mother. In addition, the same internalized other can be interviewed in a number of people at the same time (K. Tomm, personal communication, August 15, 2019).

In another variation of the practice, David Epston interviews the "externalized problem" (as the internalized other) in clients rather than interviewing an internalized other person. Interviewing, for example, "anorexia," he would ask questions regarding ways the internalized problem "maintains its grip . . . [, thereby] disclos[ing] the problem's strategies" (Bubenzer et al., 1997, p. 95). In addition to problems, a belief or an emotion can also be named and interviewed as an internalized other "to explore its 'personified intentions' and patterns of influence on the person" (K. Tomm, personal communication, August 15, 2019), thus helping to separate it from the person's sense of identity.

Burnham (2006) proposes using IOI in a similar way, interviewing "a person as an emotion, concept, or idea" (p. 32) as a way to change their relationship with that emotion. When therapists interview the externalized problem, they engage in dialogue with the person about the problem, with the aim of "explor[ing] 'mutual influences between the problem and the person'" (p. 33). In this variation of IOI, the therapist speaks directly to an emotion, which serves as an internalized other within the client, while the client acts as a witness, observing and attending to the conversation between the therapist and the emotion. It is as if the emotion is imagined to be sitting in front of the client, with the client sitting to its side, as an observer.

Another variation in the use of IOI is within the context of training and supervision. Here, the supervisor can interview an emotion or concept, "such as success, failure, ethical postures, reflexivity, cultural perspectives, and so on" (Vasconcelos & Neto, 2003, p. 20), as the internalized other of the student or trainee. This method, which can be thought of as empathy training, enables students to become familiar with the experience of this type of interview, consider multiple perspectives, and reflect on the possibilities that come with this new perspective.

A process known as interviewing the internalized other of the internalized other adds depth and complexity to the IOI process. Tomm first engaged in this practice with a psychologist who volunteered to participate in a workshop at which he was presenting. In this instance, Tomm demonstrated the practice of IOI, interviewing the psychologist's internalized father within him and asking that internalized father about his son's qualities. Tomm asked a series of reflexive questions, in an attempt to open space for the internalized father to communicate what he appreciated about his son. However, the

father continued to respond with "negative judgmental statements [that were] demeaning" (K. Tomm, personal communication, August 15, 2019). At this point, Tomm decided to ask the internalized father, "Who in your life was most positively disposed towards you, and appreciated you and your work?" (K. Tomm, personal communication, August 15, 2019). The internalized father identified his mother, whereupon Tomm asked if he could speak with her. Although Tomm was now addressing the psychologist's *grandmother*, he interviewed her as the internalized mother of the internalized father. After eliciting many positive statements from the identified other's mother about her son—the psychologist's father—Tomm thanked her, said goodbye to her, and welcomed the father back again. At that point, the father was able to say positive things about his son, the psychologist. Since that demonstration, Tomm has used this technique many times, although he admits that it can become complicated and confusing, making it even more important to repeatedly use the names of those being interviewed to firmly ground participants in the experience (K. Tomm, personal communication, August 15, 2019).

Another possibility for IOI is represented by Carlson and Epston's (2017) *insider witnessing practices* (IWPs). In contrast to the narrative therapy practice of outsider witnessing, where "the regard is conveyed by strangers or outsiders" (p. 19), in IWPs, it "is conveyed by an intimate other" (p. 19), such as the client's therapist. Carlson and Epston emphasize a key concept, the notion of "outsideness," which posits that in order for re-authoring to occur, it "must take place outside of a person's own story," where it invokes "narrative art" (p. 23). Generally speaking, we tend to live inside our stories and mostly think of ourselves as characters rather than authors, which limits our capacity for freedom and agency. As Carlson and Epston explain, "For characters in a story to have

freedom they must become their own authors" (p. 23). The IWP process offers a way to "turn therapy into a work of art where the client becomes more than a mere character of her story, where she engages with her 'yet to be storied world'" (Carlson & Epston, 2017, p. 24). Through the IWP, the client gets to "be both an author of and a character in her own story . . . as both an insider and an outsider to her own lived experience" (p. 24). Therapists using this practice then draw upon what occurs in the performance.

The IWP process consists of two acts. In Act 1, the therapist is interviewed by the supervisor "'as if' they were the client . . . . [The intention is] to reveal the essence of the [client's] moral character" (Carlson & Epston, 2017, p. 26). The therapist, having had a few sessions with the client already, is somewhat familiar with the client's experiences, and can therefore hold the client in high positive regard, knowing both the obstacles and challenges the person has encountered. This interview, which takes place without the client present, is recorded. In interviewing the client within the therapist, from the therapist's inner experience of the client's experience, the questioning process serves as a way of "privileging the [client's] competencies and resources" (K. Tomm, personal communication, August 15, 2019).

In Act 2, the client views the recording with the encouragement "to become an audience member of a portrayal of their life as performed by the portraying therapist. . . [,] who is unashamedly biased by the promise that she/he holds for the near future of the portrayed person" (Carlson & Epston, 2017, pp. 25-26). The supervisor pauses the recording at certain points, paying attention to discrepancies between the therapist's portrayal and the client's own story, and allowing the client "to attempt to resolve or reconcile the portrait contrived" (p. 28) by the therapist. Act 2 allows the client to be both

"the audience as well as an actor who actively revises the ongoing portrait of [his or her] life" (p. 28). In this way, the client is both an insider and an outsider.

In terms of preliminary discoveries, Carlson and Epston (2017) note that the distancing effect allows clients "to feel and experience levels of self-endearment and self-love that are usually reserved only for respected others" (Carlson & Epston, 2017, pp. 29-30). The authors have also found that the client, through the experience of being engaged in expressive exchange, becomes more of a character, by virtue of having emotionally moved an other. In the IWP process, time seems to be suspended. Tomm describes it as "a fascinating process . . . in terms of actually meeting one's distributed self . . . [and an] interesting new development that expands the possibilities" (K. Tomm, personal communication, April 20, 2020).

When "people are using religiosity as a way to justify their . . . impositional practices" (K. Tomm, personal communication, April 23, 2020), Tomm may interview an "internalized God" (K. Tomm, personal communication, April 23, 2020). He explains that through a series of reflexive questions, "the certainty of their knowledge about what God is meaning" can shift, as certain questions bring forth other possibilities, such as a "benevolent God . . . [rather than] the impositional . . . or frightening God" (K. Tomm, personal communication, April 23, 2020).

Contraindications, Limitations, and Special Considerations

Internalized other interviewing is contraindicated for anyone who is in a state of active psychosis, as these individuals may experience "difficulty with respect to . . . reality testing in terms of their identity and the identities of others" (K. Tomm, personal communication, April 20, 2020). Tomm clarifies that this does not preclude using IOI

with those who have had psychotic experiences, such as in the context of schizophrenia. In fact, he has found it to be particularly effective with such clients. What is required is for a person to currently be "integrated and . . . have a sense of coherent self" (K. Tomm, personal communication, August 15, 2019), and for that person to be able to have a sense of boundaries with other people.

This form of interviewing has a tendency "to bypass a person's accustomed defense mechanisms;" in the process, "people cannot defend themselves as easily as they can when they're being spoken to in an ordinary manner" (K. Tomm, personal communication, April 20, 2020). Consequently, the people being interviewed may become unusually vulnerable. This is important for therapists to be aware of, as certain disclosures may arise from the internalized other that might not come out in a more direct therapeutic conversation. Therapists using IOI must, therefore, be firmly grounded in "genuine ethical concern," maintaining a solid commitment to the client's well-being and a stance of genuine "respect and caring" ((K. Tomm, personal communication, April 23, 2020). Accordingly, therapists should avoid pursuing questions that could destabilize the client or the therapeutic relationship. Therapists who are unable to genuinely honor and respect participants if negative feelings arise are encouraged not to use IOI. Tomm offers a genuine caution that if the session is moving in a direction that seems negative, the IOI should be suspended, and therapy should take a different path ((K. Tomm, personal communication, April 23, 2020),).

At times, clients might respond as if they were the actual other person, instead of speaking from their experience of the other's experience. This can generally be identified by "rigidity in their answers" (K. Tomm, personal communication, August 15, 2019) and

redundancy in their responses. Tomm finds that inviting the person to more deeply experience their experience of the other and answer from that place, "which belongs to them [and is] part of them" ((K. Tomm, personal communication, April 23, 2020) helps create the distinction and legitimize the person to speak from this experience.

Some clients might experience IOI as difficult or feel apprehensive to speak from another's experience. This is most notably the case for "men who are highly self-centered and rigid in their view of the world" (K. Tomm, personal communication, August 15, 2019). With this type of case, which is characterized by a heightened sense of vulnerability, Tomm suggests inviting the person into the interview and, if they willingly agree, proceeding with it.

There are times when the actual other is present, and the person being interviewed answers with responses that reflect how they would *prefer* the actual other to think or feel. There are two situations in which this occurs most commonly: with couples and with a parent and his or her adolescent child. In interviews with the internalized child within a parent, the parent may respond to the questions the way they would *like* the child to, rather than from their experience of the child's experience. In a session with a couple, one member may attempt "to structure the experience of the other member, [which] usually [occurs with] men who feel entitled to want their female partners to think and feel the way they want them to" (K. Tomm, personal communication, August 15, 2019).

Tomm has devised a remedy for this, which he explains took him time to decipher, that he considers to be highly effective. For example, in an interview with the internalized wife, Susan, within the husband, John, Tomm would direct his question to John, asking, "Susan, . . . if you had the sense that John wanted you to think and feel the

way in which he *wants* you to think and feel and not have you think and feel the way you *actually* think and feel, how would *that* make you feel, Susan?" (K. Tomm, personal communication, August 15, 2019). This question would likely prompt John to reflect on what he was doing, albeit not "consciously [or] deliberately . . . [but as] a side-effect of a presumption of entitlement that people live and act, but they're not aware of" (K. Tomm, personal communication, April 23, 2020).

Due to the complexity of the IOI process, therapists could become confused about which person they are interviewing. Therefore, using the name of the internalized other in each question continually grounds everyone—therapist and client alike—in the experience (K. Tomm, personal communication, August 15, 2019; Lysack, 2002).

This chapter has served as a guide to conduct an IOI by detailing the steps involved in a proposed sequence, and how to process and de-brief the interview with the client or clients. The effects on the interviewer, the client, the actual other and the relationship have been discussed, as well as important elements to consider when using this practice. A variety of different ways to use IOI have been discussed and special considerations, limitations, and contraindications have been reviewed. In the following chapter, I will explore using IOI with specific populations and in different contexts, with clients and for training new therapists.

CHAPTER IX: IOI FOR SPECIFIC POPULATIONS

We automatically create impressions of them (and their experiences)

within ourselves, which . . . become distilled into a composite *internalized*

other within our memory and imagination.

—*Karl Tomm* (2014b, p. 236)

As previously discussed, IOI may be used in different ways, for different

purposes, and conducted with a variety of techniques. The practice can also be used with

certain populations, taking different forms depending on the context. In this chapter, I

explore the use of IOI as a training for therapists, as well as the specific uses of it with

different populations. As a systemic method that can be used with individuals in a

relational way, IOI may be the *preferred* way to work systemically in certain contexts

that warrant individuals to participate in therapy without other family members present.

An example of this may be with families in which one family member may be "falling

away from all intimate relationships" (Vasconcelos & Neto, 2003, p. 20). In these

instances, it may be indicated for the therapist to see that family member separately using

the IOI approach. This may also be the case with victims of violence or sexual abuse, or

with family members who might desire or benefit from individual sessions apart from

their adolescent or young adult children.

The IOI approach also offers a way to work with individuals who cannot

participate in family sessions due to a variety of circumstances. For those individuals who

are limited by restrictions imposed by institutions, IOI can allow people who are close to

them to be brought into the session as internalized others (Vasconcelos & Neto, 2003). In

bereavement work, the deceased person can be interviewed as the internalized other of

the loved one who is suffering from grief and loss (Moules, 2010). Similarly, therapists can address their clients as internalized others in the context of supervision and training (Hoyt & Nylund, 1997).

As a Training for Therapists

Hoyt and Nylund (1997) describe the use of internalized other questioning as an exercise for therapists that offers a means of experiencing "the process of reflexivity [and] the construction of self via the internalization of significant others" (p. 363). The exercise of internalized other questioning consists of the therapist being interviewed by a fellow therapist as their client. Tomm created this exercise, in which "the 'self' is made up of a person's internalized community of significant others" (p. 363), as a way to give therapists the experience of encountering another's experience, as if stepping into the other's shoes. It is based on the premise that our theoretical orientation directly impacts how we see and understand our clients, which then informs what we do in therapy. This exercise offers a way to facilitate and heighten therapists' awareness of what they know, how they practice, and what intentions are guiding them. Just as a therapist's approach affects their clients, it also affects the therapist.

For therapists, working with clients in ways that reflect their "best intentions for entering the therapy field" (Hoyt & Nylund, 1997, p. 361) will help them avoid burnout and provide them with "an enhanced sense of what the dictionary defines as *joy*: 'a feeling of delight, happiness, and gladness, and a source of pleasure'" (p. 362). Such a way of working highlights clients' ability to choose. Using IOI in this way opens the door for possibilities and solutions by promoting collaboration, demonstrating respect, opening space to discuss issues of justice, and moving away from pathologizing descriptions. It is

intended to help therapists "'re-member' our skills, abilities, and intentions, to help therapists use their empathy and connectedness as a source of instruction and renewal" (p. 363). When IOI is used with therapists for self-exploration, it involves therapists first being interviewed as their clients, and then as themselves. This exercise, which can also include a reflecting team to provide external voices, was designed with the intention of helping therapists become clearer and more accountable about their ethics, as well as more aware of what they might be doing well in their work with clients.

With Men Who Are Violent

Nylund and Corsiglia (1993) studied the use of IOI in their work with men considered to be "perpetrators of sexual abuse and violence" (p. 30). In the therapeutic approach previously used with this population, which conceptualized abusive behaviors "from a theory of context and restraint" (p. 30), clients were invited to explore and contest the numerous restraints preventing them from assuming responsibility for their abusive behaviors. By challenging the restraints, which can be interactional patterns, socio-cultural practices, and specific beliefs or habits, possibilities other than abuse could be considered. Additionally, this treatment model utilized questions to enable the development of empathy in the abusive males, so they could better understand the effects of their violence on their victims. Using this approach with abusive men was considered only partially successful, due to the men struggling with "grounding themselves in the victim's experience" (Nylund & Corsiglia, 1993, p. 30), as demonstrated by their propensity to guess rather than genuinely respond to the questions. Therapists seeking another method to enable these men to take responsibility for their behaviors and

experience deeper empathy for their victims looked to IOI for answers (Nylund &
Corsiglia, 1993).

Grounded in the theoretical underpinnings of this practice, in which "self is
constituted by a constellation of internalized conversations" (Nylund & Corsiglia, 1993,
p. 30), therapists using IOI were able to interview the partner or significant other within
the client and gain entry to "an 'embodied' experience of another's experience" (p. 30).
As the self is generated and established in relationship with others, another narrative
abounds regarding the self, one that places value on individuality. The dominant Western
view appears to add to "a perpetrator's inability to 'step into' the victim's experience due
to being recruited into a practice . . . that emphasises separation and minimises affiliation
and connection" (p. 31), forming a restraint that prevents an abusive person from
engaging with their victim in a more respectful and empathic way. The practice of IOI
can potentially enable the abuser to "recognise the effects" (p. 31) of their abusive
behavior and create space for them to counter the narrative that limits and restrains, that
"of the 'isolating individualities'" (p. 31). Challenging the restraints may open up
possibilities to discover "alternative individualities—ones that are associated with
reciprocity, mutuality and affiliation" (p. 31).

In the process of preparing for the IOI, the therapist cautions the person about the
difficulty they might experience answering the questions or coping with their emotional
impact. If the person challenges the therapist's statement and "argue[s] his own
readiness" (Jenkins, 1990, in Nylund & Corsiglia, 1993, p. 31), the interview proceeds.
The interview begins with the therapist inviting the abuser to address the events that led
up to the abusive behavior. From this point, the therapist shifts the focus of the interview

onto the actual abuse, followed by "attending to his sense of desperation in saving the relationship" (p. 31). At this juncture, if the person acknowledges and assumes some responsibility for the abuse, the therapist invites them to gain a greater understanding of the impact of their actions on their victim. This understanding is considered a necessary precursor for the person's ability to form relationships free of abuse in the future.

The therapist prepares to interview the victimized person within the abuser, the internalized other, by asking questions to ground them in the internalized other's experience. Throughout the interview, the therapist asks questions about the victim's experience of the abuse, its effects, and the effects of attitudes and practices of power that have promoted and justified the abuse. The interview concludes with the therapist asking the abuser to speak about their experience of the victim's experience within them.

According to Jenkins (as cited in Nylund & Corsiglia, 1993), the effectiveness of the IOI is indicated by "a *shift in the man's pattern of remorse*" (p. 31). The authors posit that this is due to the abuser's increased and more authentic understanding of the effects of the abuse on the victim, an understanding that is based more on emotional, rather than "intellectual[,] understanding" (p. 31).

Through their work with men who are violent, Nylund and Corsiglia (1993) identify some limitations to using IOI with this population. First, the IOI questions could be "somewhat confusing, complex or unnatural" (Nylund & Corsiglia, 1993, p. 34) for some clients. Furthermore, the abusers might respond how they believe the therapist wants them to, answering questions in "a contrived, superficial manner" (p. 34) instead of from a place more grounded in the victim's experience. Another possibility is that the answers they provide as the internalized victim may have been structured "according to

their own desires" (Tomm, 1992, as cited in Nylund & Corsiglia, 1993, p. 34) rather than the victim's.

Despite these possible disadvantages, the authors assert that IOI is "considerably effective in opening spaces for men to recognise the effects of their abuse" (Nylund & Corsiglia, 1993, p. 34). It provides the abuser with the opportunity to experience the effects of one's abuse on the victim in an experiential manner, enabling "more genuine remorse" (p. 34) and readying the person "to make reparations" (p. 34). Additionally, IOI can make the abuser and the therapist aware of the practices of power that influence attitudes and enable abusive behaviors, assisting both in gaining an understanding of the effects of these practices. Once such practices are brought to light, they are in a position to be challenged, thus creating an opportunity for the abusers to separate themselves from the practices. As they become further detached from this influence, they may embrace new possibilities for "alternative and preferred ways of being" (p. 34).

For Children Exposed to Violence

Hurley (2006) outlined an integrated treatment approach found to be effective with children who have experienced violence in their families. This approach uses the practice of IOI and draws upon relational psychodynamic and narrative theories. Hurley addressed the experiences of children affected by traumatic experiences who demonstrated difficulty regulating their behaviors, finding that the treatment of the children tended to focus on what the children experienced externally rather than internally. Often, such children are treated with medication and referred for behavioral interventions, which does not aid them in processing the trauma experienced. This form of treatment may invite therapists to "contribute to a form of 'narrative pathologizing' in

which vital aspects of lived traumatic experience are either minimized or ignored" (Hurley, 2006, p. 50).

The self, as "constituted in social interaction" (Hurley, 2006, p. 52), is a concept in both relational psychodynamic theory and narrative therapy. Narrative therapy, with its focus on the story, can help children recognize that the violence they experienced can be a part, rather than the central component, of their story. In narrative therapy, self develops within the context of "a narrative structure which creates a sense of integrity and social integration" (Gergen & Gergen, 1988, as cited in Hurley, 2006, p. 53). Thus, the self is oriented toward those others that constitute it, consisting of inner and outer voices with varying levels of power and influence. Mind, "as an 'internalized community of others'" (Tomm, Hoyt, & Madigan, 1998, as cited in Hurley, 2006, p. 54), is a concept that lends itself to understanding the frightening and chaotic inner life of the child who experiences violence, which, when addressed from a narrative relational approach, can help deconstruct the "self-other discourses that inform violent behavior" (p. 55) by interrupting the fusion the child has with a powerful internalized other. Once this disruption occurs, the child can distinguish between self and non-self, separating what characterizes the other from his or her own characterization of self.

The relational psychodynamic perspective holds that for children who have violent figures in their lives, those figures become part of the child's self, thereby obscuring the boundary between the child and the violent figure. Accordingly, the narrative that the child internalizes fosters "a pattern of 'repetition compulsion' and problematic re-enactments of traumatic experience" (Hurley, 2006, p. 51), which reinforces this fused sense of self and supplants the victimized and traumatized feelings.

Object relations theory posits that the self develops in the context of relationships, and the representations we have of others with whom we are in relationship become an internalized part of our self, forming the foundation of the internal dialogue that molds our "attitudes, emotions, cognitions and behavioral responses" (p. 53).

The practice of IOI allows the therapist to tap into the "inner relational world of the child" (Hurley, 2006, p. 50), bringing together the parts of their inner relational experiences to transform the narrative. Children, "by virtue of their continuing development" (p. 55) in the process of continuously internalizing others' voices, are more susceptible to enacting the stories of those they hold in highest regard, making it more challenging for them to separate their experiences from their internalized others' experiences and voices. The IOI process can help them discover their own voices, as "it empowers [them] to define self narratives . . . free from the constraints imposed by traumatic events and their aftermath" (p. 55) and to open space for other possible narratives to emerge.

Hurley (2006) identified a therapeutic approach called the Narrative Process Model, which combines the relational psychodynamic approach with the theory and practice of IOI. This approach considers "self-identity [to be] inextricably connected to narrative expression and emotional meaning making in which views of self and other are constructed" (Hurley, 2006, p. 56). It is based on a framework consisting of three levels that explore the "self-other voices" (p. 56) in the IOI. Therapy begins with an "external or storytelling mode" (p. 56), in which children speak about their experiences and memories. The next level, the "internal or emotion-focused mode" (p. 56), occurs when children explore their emotions and differentiate between their own and the emotions of

the internalized others. The third level is the "reflexive or conceptual meaning-making mode" (p. 56), which occurs following the IOI and is generally characterized by externalizing conversations.

Hurley (2006) interviewed an eight-year-old boy who had witnessed his father violently abuse his mother. Having previously received various diagnoses and medications, he was referred to Hurley due to having nightmares and "drawing violent images at school" (p. 56). His mother stated she "could no longer cope with his emotional outbursts" (p. 56). During the IOI, the therapist interviewed various internalized others, including the child's younger self at age four and the child's mother, who was witnessing the interview and, therefore, meeting her distributed self within her son. In the interview with the child's younger self at a time when his relationships were free of conflict, the:

> reconstructed memory triggered a significant change in [their] relationship . . . [,]
> which was previously characterized by a problem discourse . . . [,] help[ing] him
> to regain a part of his lost self that was rooted in acts of kindness and compassion.
> (p. 58)

The process of IOI allowed for the redefinition of "a possible future narrative no longer dominated by the legacy of violence (p. 59), thereby disentangling them from the patterns more entrenched in the problems of family life and relegating the repetitive experience of trauma "to the status of unpleasant biographical memory" (p. 59).

For the child, the experience of being interviewed as his younger self enabled him to bring forth the son he once was, "who had retreated in the face of violence and family chaos" (Hurley, 2006, p. 59). A description of himself that had been lost was revived through the process of IOI. Interviewing the internalized mother within the child enabled

Hurley to bring forth the mother's voice, which had previously been dominated "by the abusive voice of the father" (p. 59). Witnessing herself, the mother was permitted to differentiate between who she was presently as a mother and "the mother she preferred to be" (p. 58). She was able to see herself as a capable parent who was capable of accessing greater empathy for her son. By observing her son reclaim his lost younger self, "she too by proxy recovered a piece of her lost self" (p. 59).

Following the IOI, those individuals considered to be significant others can help verify and secure the new narrative. When a person speaks from the voice of the internalized other, there is a "paradoxical effect" (Hurley, 2006, p. 59) that helps bring forth and differentiate one's own emotions and voice. In this way, the fused self can be disentangled. The part that was previously undistinguished from the dominating and powerful internalized other can be brought forth through the process of IOI, thereby creating "the conditions for the uncoupling of shared emotional states" (p. 59). In Hurley's IOI with the eight-year-old child, it was necessary for the father to have previously "renounced violence and accepted responsibility" (p. 59) for his abusive behaviors. Once that occurred, the internalized father could be asked to address the harm and acknowledge its effects. As part of the IOI process for this child, other significant individuals could have been interviewed as internalized others, such as teachers or friends of the family.

One limitation or disadvantage of using IOI with children who experience violence is the potential for it to retraumatize a child who might be unable to endure the process of exploring their deeper thoughts and emotions. When this is the case, Hurley recommends using an intervention other than IOI, such as play therapy, which can assist

children to externalize their emotions and re-story their narrative. Using the practice of IOI enables one to step into another's experience, allowing "for distinctions to be made that further define self feelings, self thoughts, and self-directed behavior" (Hurley, 2006, p. 59). For children who have experienced violence, the process allows them to recover a self-narrative that can be reconstructed with this "more secure self" (p. 59). For therapists to aid in healing the narratives these children have developed about their lives, it is essential to engage them in a process of "re-visioning the self" (p. 60). The IOI approach has been found to be "a powerful way of engaging children and adolescents in self-defining stories that challenge dominant views of self and other" (p. 60), constructing new identities, and creating new descriptions of themselves and others. The emergence of new self-definitions can contest "the dominant discourse about the inevitable trajectory of violence-filled futures" (p. 60) in these children's lives. The children's experience of redefining themselves through this process has been found to also have a "systemic impact" (p. 60) on others who partake in the interview.

In Bereavement Work

Moules (2010) utilizes IOI with individuals experiencing bereavement—interviewing the deceased actual other—the internalized other—and finds it to "have powerful and healing effects" (p. 187). Moules (2010) has discovered, through applying the process of IOI, that their "experience of grief involves finding ways to say goodbye to the physical presence of someone in life while discovering how to stay connected" (p. 188)—how to remain in a relationship that continues.

Interviewing the deceased person as the internalized other has a number of possible effects that emerge from "the re-membering capacity of enlivening the voice"

(Moules, 2010, p. 189) of that person. This is most impactful for those individuals who have determined that the deceased person's voice is no longer accessible. According to Moules (2010), connecting the living person to the deceased internalized other is "akin to the hermeneutic notion of aletheia . . . [, an] ancient Greek word . . . [that] means a portal to an opening of what was once closed" (p. 189). The effects of opening this "portal" can help the grieving person remember and open up opportunities "to correct erroneous beliefs" (p. 189); to engage in conversations of goodbye or hello, of forgiveness or apology; or to talk about love or anger. Family members witnessing the interview get an opportunity to hear and speak about certain conversations that might have been necessary. An IOI may also make possible "maturational and relational changes in the internalized other" (p. 189). Reflecting on her experience using IOI with grieving individuals, Moules describes "a sense of sacredness that charged the atmosphere" (p. 197), proposing that there is an element of spirituality in this type of intervention.

The process of using IOI with this population first begins with the therapist's determination that the timing and intention of the interview will serve the client well. Moules (2010) finds it useful to move to the next step in the process without much discussion or explanation about IOI, instead simply stating, "'I'm wondering if you would permit me to do something. I would like to interview Andrew in you. Would this be something you would allow me to do?'" (pp. 190-191). Clients usually agree, at which point Moules instructs them to speak from the "I" position of the deceased within them and lets them know that she will be referring to the internalized other by their name. In IOI, the first questions are generally linear and simple; however, in this context, questions usually refer to a previous time in the relationship. The line of questioning will be

directed toward the particular issue the client is presenting in therapy. For example, it may involve anger, guilt, or movement toward apology and forgiveness. The therapist then asks the internalized other if there are any other questions they want asked. Following the interview, the session shifts toward processing the experience. The therapist asks the actual other to reflect on the interview, which may include speaking with others who may have been present. Following this, the therapist asks more specific process questions regarding the interview itself, asking about "observations, reflections, and insights" (Moules, 2010, p. 191).

With this specific population come particular indications for use, most notably related to timing and the needs of the client. Cues for when to use IOI include when a majority of the session involves conversation attempting to connect the client to the deceased; when clients seek answers that they cannot seem to access; when clients express anger or feelings of guilt, and it appears that "conversations of grace, forgiveness, or apology may be useful" (Moules, 2010, p. 189); when clients are suffering because they have things they wanted to say but did not have the opportunity to do so; and when assisting a client to re-member will be helpful (Moules, 2010).

The timing of when to use IOI with the bereaved is an extremely important factor. It is considered unwise to interview the internalized other if the loss is recent, as individuals who are "acutely grieving" (Moules, 2010, p. 190) have a reduced ability to reflect. Thus, Moules (2010) determines that it is better to use this practice at a later time, when the bereaved is not in such "acute pain" (p. 190) and can access the internalized other more readily. Moules asserts that IOI is contraindicated in certain circumstances, such as if the client has "personality disorders such as narcissistic or borderline . . . [,] if

the bereaved had tremendous anger issues with the deceased[,] or if the relationship had been traumatic and abusive" (p. 190). In such circumstances, it is best not to imply that the deceased is internalized within the client. Nevertheless, Moules notes that interviewing the deceased internalized other within a client has profound healing potential, as it opens space for the client's well-being and increased connection to a significant other. As she explains:

> The hollow that is carved out in grief often is not as empty as it feels. Our internalized communities are accessible as continuing influences in our lives, offering commentary, love, connection, history, and holding the potential to offer healing words. They just need to be invited into the conversation. (p. 198)

For Those Not Present

As previously mentioned, the practice of IOI can be used in conversations in which the actual person being interviewed is not present. This section, however, refers specifically to the work of Haydon-Laurelut and Wilson (2011), who work to support individuals "with severe intellectual disabilities (ID); those with challenging behaviors; and those with high communicative support needs" (p. 24). There are a number of reasons a person may not be present in therapy, which gives therapists an opportunity to work on behalf of the clients by working with those that support them, such as staff and family members. Working with an individual who supports the client might be indicated when the person being referred may not realize a problem exists, when the description of the person's issue could be disparaging, or when the person may not possess the skills required to respond (Haydon-Laurelut & Wilson, 2011).

When such individuals are referred to therapy, professionals tend to refer to them using problem-saturated descriptions, "reflecting or drawing upon dominant understandings of disability circulating in the wider culture" (Haydon-Laurelut & Wilson, 2011, p. 27). They typically view disability through an individualistic lens and from a medical model perspective, in which the disability resides within the person. Holding this perspective, the people who support individuals with ID may understand them as needing "rehabilitation (fixing) or sympathy" (p. 27). At times, those caring for and supporting people with ID "can forget they are real people who need to be loved and need to be powerful" (Haydon-Laurelut, 2013, p. 7). People with ID, while "not 'invisible to themselves' . . . may be invisible to others" (p. 7), especially if they have been labeled as problematic.

The field of "Disability Studies . . . [has] . . . developed alternative narratives of disability as found in the social world and not in the bodies (or minds) of disabled individuals" (Haydon-Laurelut & Wilson, 2011, p. 27). This discipline explores what is known as "ableist" culture, which does not permit inclusivity for those with disabilities. Thus, the people who support individuals with ID, the individuals themselves, the family members of the individuals, and the systems within which they live and work, make sense of their experiences and identities through the lens of the limiting pathologizing cultural discourse. Based on this understanding, therapists utilizing IOI with this population can promote inclusion. Murray (as cited in Haydon-Laurelut, 2013) explains:

> We only begin to attend, in any meaningful sense of the word, to another's well-being when we acknowledge the reality of their internal experience. Such attention in turn elicits richer and more complete pictures of that internal reality.

Just as the absence of empathy and absence of respect operate as cause and effect of one another in a vicious circle of exclusion, so do their presence working in mirror image of the same dynamic, create the virtuous circle of inclusion. (p. 7)

Using IOI in this context, the person responding to the questions (i.e., the caregiver) does so from the position of first position. Accordingly, they are able to speak more freely about their experiences without being hindered by the usual constraints one generally has when responding to or from the position of third person. A question posed in the third person would be something like, "'Really? What makes you think that he is angry?'" (Haydon-Laurelut & Wilson, 2011, p. 35), whereas one posed in the first person would be, "'What makes you think you are angry'" (pp. 35-36). As Haydon-Laurelut and Wilson (2011) explain, those speaking from the first-person position "are usually accorded the right to remain unchallenged when making such statements" (p. 36).

At the start of the interview, the therapist extends "an implicit invitation" to the interviewee, in this case the caregiver, to assume the position of advocate for the client, "positioned to speak as [that person] rather than for oneself, one's organization, or profession" (Haydon-Laurelut & Wilson, 2011, p. 36). This presents a meaningful contrast to what generally occurs, which is a process of the caregiver complaining about the person with ID.

Drawing from Tomm's development of IOI, which he refers to "as a practice of 'relational responsibility,' it can thus be re-theorised and re-employed as an anti-disablement practice; a resistant practice in the face of denials of personhood" (Haydon-Laurelut, 2013, p. 7). Using IOI with a caregiver when the individual with ID is not present begins with the therapist "warming the context and providing information"

(Haydon-Laurelut & Wilson, 2011, p. 28), providing the caregivers of the individual with ID with information about the process, and inviting them to decide who will be in the role of the internalized other. Once a staff member is selected, the others form a reflecting team. As the IOI begins, the therapist asks the staff member orienting questions to help ground the person, referring to them by the name of the individual with ID, and then asking relational questions focused on the internalized other's "experiences, of inclusion, of life events, and significant relationships" (p. 29). The therapist also asks the internalized other about exclusion, asking more about the person's context and experience rather than about problem description. Episodic questions are also included in the interview, which focus on those interactions with others involved in the issue that prompted the referral, "often a pivotal episode where the worries of supporters escalated" (Haydon-Laurelut, 2013, p. 9). Next, the therapist asks appreciative questions about the internalized other's interactions with the support person, exploring what the internalized other may appreciate about the actual other.

Once the interview is complete, the staff members comprising the reflecting team share their reflections, and the therapist invites the staff member who was interviewed to return to their own voice. They then reflect on the experience of speaking from the experience of the internalized person with ID. A discussion about possible actions ensues that can solidify the knowledge gained through the interview.

Haydon-Laurelut and Wilson (2011) found in their study that through their reflections of the IOI process, the support staff were "moved by the powerlessness of the person over their environment" (pp. 32-33). The staff paid greater attention to the limited number of prospects the person with ID had to communicate. They noticed that they had

become so involved in their work that they no longer thought of the person they

supported as a person at all. They spoke of the effects the events had on the person's life,

were surprised to find that they knew more about the person than they had realized, and

were able to create plans of action to help make the person's life better.

The IOI approach is beneficial for staff members working with individuals with

ID, as it provides the opportunity to create changes in a team's way of understanding and

working with the people they care for. During IOI,

> the conversations . . . step . . . away from the language of blame . . . to the
>
> language of experience . . . ; from accounts of behaviors . . . to accounts of
>
> thoughts . . . and   emotions . . . ; from the language of certainty . . . to . . .
>
> uncertainty . . . ; and from the language of hopelessness to new ideas and their
>
> potential for change. (Haydon-Laurelut & Wilson, 2011, p. 33)

Based on their experience using IOI with this specific population, Haydon-

Laurelut and Wilson (2011) assert that the practice is an effective way to invite and

attend "to the voices of those whom we may struggle to include in the therapy room" (p.

36). For this population in particular, IOI offers a chance "to loosen the grip of such

reductionist disabling understandings of a person's life—bringing persons back into

relationship . . . [and] changing the positions . . . in a way that invites new conversations

via a novel moral order" (p. 36).

In this chapter, I have shown a variety of ways that IOI can be adapted and

adjusted for specific populations, for different purposes, and with different therapeutic

intentions. The next and final chapter of this dissertation will bring together all that has

preceded in the discussion of IOI. I conclude by expanding upon what is presently known

about IOI and offering ideas and possibilities about future research, as well as

implications for the use of this unique interviewing practice for the field of family

therapy and beyond.

CHAPTER X: DISCUSSION AND IMPLICATIONS

In other words, we shall remain human only as long as our operation in love and ethics is the operational basis of our coexistence as languaging animals. Indeed, living in the negation of consensuality, of love and of ethics, as the grounding of the different manners of our coexistence, constitutes the negation of humanity. Of this we can be aware now.

—Humberto Maturana (1988, p. 49)

In this chapter, I reflect on Karl Tomm's unique practice of IOI and propose the present and future implications and possibilities of this work, with regard to research and practice. I then explore some ways that it can contribute to the field of family therapy and be applied in other contexts.

I will venture to assume that many of us therapists working from a second-order perspective strive to foster an empathic connection with our clients. For change to occur therapeutically, for our clients and their families to experience wellness, connecting on this level is a necessary part of the process. It enables us to get as close as we can to another person's lived experience and forge the deep connection that comes with stepping into another person's shoes. The IOI approach offers us, and our clients, this opportunity.

Implications and Possibilities for the Field of Family Therapy

The field of marriage and family therapy is practiced in various settings, where therapists assist clients in ways that support their sense of well-being and promote social justice through all the phases of human development. Clinical work with individuals, couples, families, and groups can take place in residential inpatient settings, outpatient clinics and agencies, prisons, schools, clients' homes, and more. Since IOI promotes a

"significant process of generating understanding about another person's understanding" (K. Tomm, personal communication, April 20, 2020), it can be applied to and utilized in any of these settings.

Therapy clients within certain settings, such as schools, medical clinics, prisons, and substance abuse treatment centers are considered to be the *primary client* in the therapeutic process. In systemic practice, however, therapists' work with such clients is expanded, in a more holistic way, to extend beyond individualist constructs and move into the relational space. In each of these settings, IOI can provide an opportunity for the individual clients, students, patients, or prisoners to move beyond their individual issues and work relationally, deepening their understanding of the important relationships they were previously involved with, are presently engaged in, or hope to resume.

For clients in these settings, IOI can promote the emergence of new patterns of interaction and healthier, more meaningful relationships with partners, families, teachers, and co-workers. Additionally, the internalized other, as discussed previously, is not limited to being an internalized person; it can also be an internalized emotion, thought, value, or cultural practice. For example, when working with a client in medical family therapy or substance abuse treatment, a medical diagnosis or drug of choice can be interviewed as the internalized other, thereby externalizing the internalized problem to enable the deconstruction and co-construction of a different relationship with the chosen other.

For the family members of clients in medical family therapy settings, the IO can be the client. This allows the family members to better understand their loved one and their medical issue. Interviewing a family member within the client can facilitate the

client's understanding of the family member's experience with their medical condition, or with being a caregiver.

In substance abuse treatment, a client's internalized other can be a family member. This allows for an exploration of that person's experience in relationship to the client. The internalized other can be a belief about sobriety, abstinence, or harm reduction; it might also be an emotion, such as shame, guilt, resentment, anger, co-dependency, sadness, or grief and loss.

This type of interview can be used with many populations—e.g., families of sex offenders, caregivers of family members, grandparents who are raising their grandchildren—and can serve to address many family issues—e.g., distress related to finances, divorce, adoption. When IOI is used in the case of adoption, the therapist can interview the biological parent as the internalized other within the child, or the child as the internalized other within the biological parent. Alternatively, the internalized other can be the adopted child within the adoptive parent, or the adoptive parent within the adopted child. In families that include both adopted and biological children, the parents can be interviewed as well as the children. For example, the internalized other can be the adopted sibling within the biological sibling or, conversely, the biological sibling within their adopted sibling. The IOI can also be used effectively with blended families, for the parents and children to gain a greater understanding of one another's experience in this new family structure.

In relationships characterized as high conflict—common in family situations involving domestic violence, marital distress, divorce, blended family situations, or parental alienation, as well as in school situations such as conflicts among students or

between students and teachers—IOI can be utilized as practice for conflict resolution. Just as IOI can be implemented with couples to address high conflict, it can also be used to explore and develop a greater understanding between people experiencing issues such as infidelity, infertility, and sexual health issues. In such cases, one person may appear to be more self- rather than other-oriented; for that individual, IOI can serve as an "invitation to move [from self-centeredness] towards other-centeredness," as it is a "deeper [way of doing this that is] more fully grounded within the experience of the other" (K. Tomm, personal communication, April 20, 2020).

Couples and families experiencing issues related to their identification as multiracial, interracial, interfaith, and intercultural can find IOI to be beneficial. For couples, in general—particularly those that demonstrate "interpersonal patterns that are limiting and perpetuate monologues" (K. Tomm, personal communication, August 13, 2019)—IOI creates dialogue. It provides the scaffolding for people to re-author "themselves and relationships as they exist in the other" (K. Tomm, personal communication, August 13, 2019).

Issues related to aging can be addressed using IOI. The therapist can interview the older adult who is struggling with the aging process as the internalized other within a younger family member, or the younger family member can be the internalized other within the older adult. In either case, IOI can help the family members gain a deeper understanding of one another's experience. Time can be altered within the IOI process, so that the therapist interviews the older person's younger self or older self within their current self. For couples aging together, one can be interviewed within the other to

explore issues related to the loss of friends, family, health, functioning, purposeful activity, community involvement, and connection.

The IOI process in the context of bereavement, discussed previously, can be extended to include interviews with the internalized other as the partner, spouse, child, sibling, or parent who has passed away within the person struggling with the loss. There are many applications for interviewing the deceased individual as the internalized other within surviving loved ones. This type of interview can address emotions within the grieving person or people related to losses such as the loss of a pregnancy—due to miscarriage, ectopic pregnancy, still-birth, or abortion—or the loss of a child—due to suicide, illness, trauma, or surrendering or relinquishing one's parental rights.

Clinical issues including anxiety, depression, eating disorders, post-partum depression, and phobias can be interviewed as the internalized other within the client, to create a context for deconstruction, externalization, and co-construction. Similarly, childhood behavioral issues—such as childhood obesity, divorce, and issues related to a parents' abuse of alcohol or other substances—can be addressed to great effect with the IOI process. With adolescents who self-harm, the therapist can interview as the internalized other the adolescent's younger or older self, during a time when the self-harm behavior was not, or is no longer, occurring. In the context of bullying, the therapist might interview the bully as the victim, to foster a deeper understanding of the victim's experience. In cases involving child abuse, neglect, or sexual abuse, the therapist can interview the abused or neglected child as the internalized other within the abuser.

The IOI approach can also be utilized with people dealing with LGBTQ-related issues, such as concerns related to sexual identity or gender identity, same-sex parenting, the coming out process, or same-sex relationship challenges. Not only can IOI be used with LGBTQ-identified individuals and couples, it can also be used with family members who may experience difficulty accepting a loved one as LGBTQ, with the therapist interviewing the LGBTQ individual as the internalized other within them. Conversely, the family member can be interviewed as the internalized other within the person who identifies as LGBTQ.

Another application of IOI is with issues related to culture, diversity and inclusion, and immigration issues, such as deportation, residency, citizenship, refugee status, and family separation. Socio-cultural issues can also be addressed, with the therapist interviewing the internalized other in the form of a belief related to a person's social context or culture. For example, the internalized other can be machismo or a particular religious or cultural viewpoint. The interview can be conducted in multiple variations: an individual, belief, viewpoint, emotion, or problem experienced by the individual can serve as the internalized other. Or, in the case of a client who is experiencing the pathologizing effects of a belief or viewpoint held by a loved one, the person holding the belief can be the internalized other within the person. Similarly, the therapist can interview the internalized other's belief within the internalized other (i.e., the person holding the belief)—in other words, interviewing the internalized other of the internalized other.

In Chapter IX, I discussed how IO can be used in the training of new therapists. This practice can also be used in various contexts within the university environment, such

as in academic classes or clinical supervision. In family therapy programs, IOI can be used as a small group experience in classes that teach diversity, to deepen students' understanding of marginalized populations and one another's diverse backgrounds. In doctoral level programs that include classes that teach about Bateson and Maturana, a course could be developed that brings various post-modern theories and clinical approaches together through the lens of Karl Tomm's IOI. It could also be applied to the training of students in medical family therapy to facilitate their understanding of other team members' roles and experiences. In the supervision setting, IOI could involve interviewing the internalized supervisee within the supervisor and the internalized supervisor within the supervisee to promote and facilitate greater understanding within the supervisory relationship.

With any of the issues discussed above—clinical work, education, supervision, and training—interviewing a client in the presence of the actual other, who is interviewed as the internalized other within the client allows for "the observing actual other . . . to understand how the person being interviewed understands them by listening to the voice of the internalized other within that person" (K. Tomm, personal communication, April 20, 2020). In this dual interview process, the actual other has the opportunity to see his or her distributed self in the other person. As a result, "that person suddenly comes into a new understanding of the other and their relationship with the other" (K. Tomm, personal communication, April 20, 2020).

As discussed in Chapter VIII, the person being interviewed (i.e., the actual other) experiences many effects from the IOI process. The interview also affects the relationship, most significantly with respect to the issue of responsibility. Whether it is an

increased awareness of one's interactions and their effects, a shift in understanding about the other, greater curiosity or empathy for the other, or an opportunity to "correct misguided beliefs" (K. Tomm, personal communication, August 15, 2019), assume responsibility, or experience mutual appreciation and respect, IOI has vast implications and possibilities for the field of family therapy. Beyond the therapy room, the practice of IOI can be applied in other contexts, with systems in which the participating individuals might benefit from a greater understanding of another human being's experience.

Applications and Implications in Other Contexts

The practice of IOI can be applied in contexts beyond the field of family therapy, in order to facilitate negotiations, reconcile differences, or achieve a greater understanding of another's experience. It has promising implications for work in the areas of conflict resolution and peace, business, spirituality and religion, politics and policymaking, diplomacy, and human resources.

Any sector or system of our society in which differing perspectives might create dissention, impasse, or conflicts can benefit from the use of IOI. In the business sector, an employee can be the internalized other, interviewed within their supervisor or manager, or the internalized boss can be interviewed within the employee. This has the potential to assist in human resource related issues such conflicts or misunderstandings between employees. Issues that arise among employees in a family business can also be addressed and mitigated using IOI.

In the systems of national politics and government, possible applications of IOI include interviewing a constituent as the internalized other within a political representative, interviewing an internalized politician within a constituent, or

interviewing a political party member within an opposing party member. In the recent political climate, there have been many instances of groups or caucuses using certain beliefs to justify impositional actions and practices. With IOI, it is possible to interview an internalized political belief, thereby bringing forth the more generous, loving, and compassionate elements of a person's belief system and fostering a deeper understanding of one another's position or stance. There are implications for IOI in the context of international relations as well, involving heads of state or international leaders in the process to promote negotiations and resolve conflicts.

There are implications for the use of IOI in the education system and higher education settings. It can be used with school principals and their teachers; with teachers and their students; with students and their classmates; and, in the context of school-based family counseling, with parents and their children. In higher education, IOI can be used to facilitate understanding between departments and among deans, faculty members, heads of student organizations, and students. In programs that provide professional training, such as allopathic or osteopathic medical schools, it can be used for interviewing an internalized patient within a professional-in-training.

Future Research Possibilities

Although IOI has both a strong theoretical foundation and broad clinical applications, research into its use is limited. In Chapter VII, I discussed the two existing studies of IOI, a quantitative study that looked at possible short-term effects of this type of interview, and a qualitative study that used three discursive methods to explore the dialogue of an IOI with archival data. In this dissertation, I have presented a detailed exploration of the foundation and practice of Karl Tomm's IOI. Through this process, I

have come to discover its complexity and richness, which has opened the door to the boundless possibilities for its use in family therapy and other contexts. Grounding IOI upon this matrix reveals opportunities for a plethora of research studies that may be considered for exploring the many aspects of IOI.

The effects of using IOI—with clients and students, as well as with the therapists and supervisors who conduct the interviews—can be explored using both quantitative and qualitative methods. Researchers conducting quantitative studies can use various measures of assessment to determine the immediate, short-term, and long-term effects of IOI on clients, on clients' relationships (when the actual other is present in the process), on the interviewer, and on the therapeutic relationship. The practice of IOI can also be studied in the context of its use with different client populations and in various contexts regarding its efficacy.

The yet undiscovered aspects of IOI can be uncovered using a qualitative research design, which is the most appropriate method when "a problem or issue needs to be explored and a complex detailed understanding of the issue is needed" (Creswell & Poth, 2018, p. 46). Rather than seeking outcomes that are "generalizable and objective" (Whittemore et al., 2001, p. 524), qualitative inquiry explores "depth over breadth and attempts to learn subtle nuances of life experiences . . . [, characterizing it as] contextual and subjective" (p. 524).

Interpersonal Process Recall (IPR) is one example of a research method that can be used to inductively explore IOI and capture a rich description of themes that might emerge from of an IOI session. As a process method, IPR allows for the examination of "psychological events in ways not previously possible" (Kagan & Kagan, 1991, p. 221).

Using this method to explore IOI would provide access to the experiences of the therapist and client that are "as close to the moment of interaction as possible" (Larsen, et al., 2008, p. 19). This approach makes it possible for researchers to study and "access clients' unspoken-in-session experiences as they are remembered to have occurred during the session" (Larsen et al., 2008, p. 20). Researchers are able to receive explanations and illuminations from the participants regarding their in-session experiences, exploring them from multiple perspectives. Thus, this method of study appears to hold great promise for further expanding an understanding of IOI.

Researchers using a qualitative research design such as IPR can seek to explore clients' experiences of the IOI process, as well as the effects it has had on them and their relationships. Such studies could also explore IOI from the perspective of the therapist conducting the IOI, to gain a greater understanding of their experience of the session, note particular moments of resonance, and understand the logic informing certain questions. An IPR can shed light on how, and in what ways, therapists move the session forward, exploring their intentions behind certain decisions, such as determining which partner in a couple acts as the internalized other. Additionally, IPR can be used to explore the effects of the IOI on the therapist.

In my endeavor to navigate and understand the course of Karl Tomm's evolving professional journey and how it has come to inform his practice of IOI, I discovered a recurring theme. In each phase of his process, whether being influenced by or contributing to the field, he has demonstrated a personal commitment toward thoughtfully reflecting on his own clinical work and on the intentions and effects of his and other professionals' actions and words. He has done so with "honesty, . . . clarity of thought,

and . . . personal soul-searching" (Tomm et al., 2001, p. 261), looking at his looking, engaging in reflective and reflexive dialogue, collaborating, challenging himself, and expanding as he continues his evolution of "becoming" (Tomm et al., 2001).

Tomm's ethical commitments are fundamental to all of his relationships and interactions, whether with clients and their families, students, colleagues, professionals, communities, or the systems with which he has engaged. Influenced by early personal experiences and later clinical work, he further developed the ideas that informed his ethical postures, grounding his work in the dynamic of mutual therapeutic loving to enable the unfolding of possibilities and cultivate well-being. Ever mindful of the effects of his actions, he has written about our responsibilities as therapists: "Not taking a position is taking *the position of not taking a position*, which is to support the status quo" (Tomm, 2014b, p. 243). Accordingly, he is respectful of the position he assumes, or does not assume, and remains aware of the intentions guiding his interactions.

Working from his preferred ethical posture of empowerment, Tomm strengthens his posture by organizing his own emotional dynamics, aiming to avoid "therapeutic violence" (K. Tomm, personal communication, August 12, 2019) and instead, increase options and open space for wellness, or "therapeutic loving" (K. Tomm, personal communication, August 12, 2019). His definition of loving builds upon Maturana's conception of it as "acknowledging the legitimacy of the other in relation to the self" (Tomm, 1998a, p. 185). Tomm adds another dimension, viewing love ethically and therapeutically as "not just opening space for the existence of the other" (Tomm et al., 2001, p. 257), but as "opening space for the enlivened existence of others" (Tomm et al., 2001, p. 257).

Being selective about integrating existing knowledge, or "being in touch with one's own intuitive experiences [and] with one's experience of the client's experience" (K. Tomm, personal communication, August 12, 2019) is yet another way to strengthen one's posture of empowerment. This can be practiced by looking at context, sharing one's understanding of the client's experiences with the client, and privileging the descriptions that have greater therapeutic potential. In his work with clients, Tomm pays attention to "recursioning" or being mindful, "coherencing" or being congruent, and "authenticating" or being honest (K. Tomm, personal communication, August 12, 2019).

The practice of IOI, as developed by Karl Tomm, reflects the thoughtful and self-reflective development he has demonstrated throughout his evolutionary journey, "from being a psychiatrist, to becoming a family therapist, to becoming just a therapist, then becoming a human being" (Tomm et al., 2001, p. 256). Speaking of his developmental process, Tomm (as cited in Tomm et al., 2001) explains:

> I want to be a 'human becoming' . . . to keep on evolving . . . to acknowledge in myself all of my possibilities or potentials . . . and if I can get in touch with those possibilities [, then] I can work more effectively with whoever I'm working with. (p. 256).

The IOI process opens space for more profound levels of understanding between people, thereby making room for deconstructing and co-constructing possibilities to emerge. My hope that this dissertation will illuminate and illustrate the practice of IOI aligns with Tomm's (2014b) hope that

> over time, as more and more people in families, communities, and cultures co-construct greater collective awareness of our interactional origins, we will become

stronger and stronger in generating more mutual invitations for wellness as we

journey forward in our living together. (pp. 246-247)

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Appendices

Appendix A

Non-Human Subject Research Memo

NOVA SOUTHEASTERN UNIVERSITY
Institutional Review Board

MEMORANDUM

To: **Robin Akdeniz**
Dr. Kiran C. Patel College of Osteopathic Medicine

From: **The System,**
Institutional Review Board

Date: **September 8, 2020**

Re: **IRB #: 2020-425; Title, "Karl Tomm's Internalized Other Interviewing: From Theory to Practice"**

Based on the information provided, your protocol does not require IRB review or approval because its procedures do not fall within the IRB's jurisdiction based on 45 CFR 46.102. Therefore, your protocol has been classified as "Research outside the purview of the IRB" for IRB purposes; your study may still be classified as "research" for academic purposes or for other regulations, such as regulations pertaining to educational records (FERPA) and/or protected health information (HIPAA).

This protocol does not involve "human subjects research" for one of the following reasons:

(a) The study does not meet the definition of "*research*", as per federal regulations: "*research*" means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

(b) The study does not involve *"human subjects,"* per federal regulations. "*Human subject*" means a living individual about whom an investigator conducting research obtains:
    (1) Data through intervention or interaction with the individual, <u>or</u>
    (2) Identifiable private information.

(c) Other:

Please retain a copy of this memorandum for your records as it indicates that this submission was reviewed by Nova Southeastern University's Institutional Review Board.

The NSU IRB is in compliance with the requirements for the protection of human subjects prescribed by Part 46 of Title 45 of the Code of Federal Regulations (45 CFR 46) revised June 18, 1991. Cc:

Cc: **Douglas Flemons, Ph.D.**
Robin J Jacobs, Ph.D., M.S.W., M.S., M.P.H.

Biographical Sketch

Robin Akdeniz began her professional life as an Occupational Therapist, earning her degree from Boston University in Boston, MA. She then went on to be a hand therapist at Columbia Presbyterian Medical Center in New York, serving as the supervisor of the outpatient clinic, where she treated patients and supervised student interns. She also taught courses at Columbia University and published a paper on using myoelectric prostheses with upper extremity amputees. After raising a family, Robin returned to school to pursue her MSW, graduating from Florida Atlantic University in Boca Raton, FL. She became licensed as an LCSW, first working in the student counseling center at Palm Beach State College and then in substance abuse agencies with residential and outpatient clients, which led her to earn her Certified Addiction Professional (CAP) credential. She went on to serve as a counselor for Jewish Family Services in Boca Raton, FL, where she provided individual sessions to clients. Subsequently, she opened her private practice, where she presently works with individuals, couples, and families.

In 2015, Robin began the Ph.D. program in Family Therapy at Nova Southeastern University. From 2014 to 2017, she taught as an Adjunct Professor at FAU in the School of Social Work, and from 2017 to present, she has taught in the School of Human Services at Palm Beach State College. Robin has taught both graduate and undergraduate courses in solution-focused therapy, group therapy, advanced group therapy, substance abuse, introduction to counseling, advanced practice with individuals, and advanced practice with groups and families. She has presented at the Solution Focused Brief Therapy Association's annual meetings, been a guest speaker in Ph.D. classes at NSU,

and given a full-day workshop in SFBT to MSW interns in the school system. Robin has

published a book chapter on SFBT for multicultural families in *Solution-Focused Brief*

Therapy: A Multicultural Approach edited by J. Kim. She is a member of NASW,

AAMFT, and a qualified supervisor for MFT and CSW registered interns.