8. Seeking authenticity as a researcher.

Introduction

This chapter is about a more conscious effort to explore how my practice and the research methodologies and ideas presented so far could become more intertwined. Whilst the constructivist ideas from Lincoln and Guba's Naturalistic Inquiry had spoken to my practice (and my thinking about practice), and had helped elaborate my appreciation of epistemological considerations, I felt that the action research methodologies were still 'waiting in the wings'. My central concern was about gaining explicit collaboration from others to join me in inquiring into the issues involved in working with 'complex cases'. Both Cooperative Inquiry and Collaborative Inquiry as I saw them required this as a first step. I could not become an 'authentic' researcher until I had gained this.

I present two stories here to illustrate my dilemmas in achieving authenticity and collaboration. The first is about my attempt to put into practice an element of Torbert's 'experiments in practice', through use of his Framing/Advocating/Illustrating/Inquiring interpersonal strategy. I did this in the context of an episode of practice in which I departed from my usual role of coordinating care and came away feeling that I had been inauthentic as a practitioner, and clumsy in my use of Torbert's inquiring interpersonal strategy which I felt had hindered rather than helped. I felt doubly inauthentic, as both a practitioner and as a researcher.

The second story is one in contrast to the first. I did not engage in conscious use of Action Inquiry strategies, but rather I paid more attention to the constructions held by the different 'actors in the drama'. I found the results to be much more satisfying to me as a practitioner and I saw the process and the outcome as being informed by the increasingly detailed 'map' I had constructed of how the department functioned, as described in the previous chapter. I felt this 'map' allowed me to gain the necessary degree of collaboration to effectively resolve a 'painful' situation. However, this story troubled me as a researcher because in it I felt increasingly removed from the possibility of gaining the explicit collaboration I was seeking as a criterion for beginning the 'research proper'.

The outcome of both stories for me as a researcher was a heightened sense of dissonance between practice and research, and this tilted me towards a crisis.

Both these stories were written around the time of the occurrence of the events reported in them. Apart from some polishing in response to successive readings, and in response to feedback from supervisors, fellow research students at Bath, and family, they are presented here as initially written. My story-telling style this time is a more narrative one without dialogue, and I claim the warrants I laid out earlier for these two stories. This is my representation of the 'truths' as I saw them, taking into account my own framings purposes and values, and presenting others’ views as authentically as I can within my understandings of them for the purpose of this research. There are other 'slants' on the episodes which could be told, or other stories within this which could be elaborated. The ones I present here are written as the ones which I experienced. I make commentaries on the meaning I take from these stories, both in action and at the time of original writing, and now at the time of creating the final research narrative.

Eddie's story - seeking authenticity as a researcher.

Because this case linked so many issues together for me I found it difficult to write about at the time. As I read it now I see it so much more richly, through the lenses which I subsequently developed. However, I wish to honour how I made sense of it at the time so that I keep to my purpose of telling the story of my development as a researcher as an unfolding journey of discovery. It will be difficult to authentically relate the frustration and the sense of self doubt this episode created in me, so I am noting this now. To aid this I will develop the story in terms of the action around the case, my reading of the issues, and my attempts at being explicit in creating an 'inquiry niche'. This latter term refers to my conceptualisation at the time of how I might proceed with research - exploring possibilities within

relationships or around episodes for further explicit collaboration and participation in such a way that it constituted 'research' and not 'merely practice'.

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Eddie.

Eddie was a young powerfully built man of mixed Afro-Caribbean and European origins who lived in another district some distance away. He was an injecting drug user who had been referred by a General Practitioner who supported the local drugs services. The GP had been prescribing the injectable opiates but had unilaterally withdrawn this because of Eddie's inability to "keep to the rules" as he saw it. The only option he had offered was a detoxification followed by admission to a long term rehabilitation centre. We were asked to provide the detoxification as the rehabilitation centre was located nearby. This was not Eddie's preferred course of action at the time but he felt the only other option open to him was to revert to street drugs and the criminal lifestyle needed to obtain and pay for them. He had also been made homeless and so felt that street drug option held too many risks for him. However, he saw himself as still being heavily dependent on drugs and very ambivalent about becoming drug free.

Eddie presented himself to me as someone who was both 'street wise' and at the same time familiar with institutions. From the outset he quickly told me about his history of being in care as a child, followed by periods in psychiatric hospitals in adolescence and early adult life. He used 'therapy' language with an easy familiarity which suggested a certain sophistication while at the same time impressing as being boyish and vulnerable. He told me how he tended to leave hospitals after conflict with staff where there was threatened or actual violence on his part and asked that whatever the outcome of his admission here that he be "able to leave with dignity". Despite his apparent frankness and ease with which he had related this to me, I was left feeling as though I still knew very little about him as a person. Already around the ward he had been noted to be emotionally labile with a low tolerance to frustration and given to storming off if his needs were not immediately met, then coming back contrite some time later.

Because we had a rehabilitation centre on our 'back doorstep' we were often asked to provide detoxification prior to entry on behalf of services throughout the country. This meant that we regularly admitted people to find that there was much relevant information which had not been given to us earlier on and that this could change the goals. It could lead to admissions which were inappropriate and costly, both to the person and to the services involved and at this stage we had not developed procedures to improve this.

The Senior Registrar had completed the initial assessment of Eddie and had arranged the admission before referring him to me for psychological treatment of a particular problem. Eddie used opiates by injection only and did so in a compulsive manner which he felt was beyond his personal control and hence unable to stop. The significance of this for the admission was that he was unable to transfer easily to an oral form of opiate necessary for a medically safe detoxification. My task was to provide psychological treatment for his compulsive behaviour so that he could then proceed with his detox.

I decided I would limit myself to this specific role and leave the wider responsibility for the case with the Senior Registrar who was his Key Worker (a role we had by then begun developing, one which involved overall responsibility for monitoring the 'Patient Journey' through the service). I had not been part of the original assessment, goal setting or contracting about the nature of help to be given. Neither had I been in contact with the referring agency or met with the client prior to the admission to take part in any negotiations about what would be the most appropriate form of help at this stage.

Because I had no direct control over scripting with drug dependent clients I decided I would not get involved in that aspect of his care. I had found that role too frustrating in previous cases. The role I had been asked to take felt like a more traditional psychologist's role - take on only those aspects of the problem over which you have control of the expertise and the resources. Despite seeing many pitfalls, I decided I was going to keep to it in this instance.

In referring to the 'traditional psychologists' role, I do not wish to demean what many psychologists who work within multidisciplinary teams are trying to achieve, it is more a limitation of the prevailing model within clinical psychology with its treatment methods strongly rooted in the traditional science paradigm. However, many psychologists work outside multi disciplinary teams in isolation, taking on only those problems which fit their chosen model/s.

As I began to work with Eddie and find out more about the circumstances around his admission, the more I began to wonder at how I was going to succeed in keeping to the narrow role I had elected to follow. I did not feel his host agency had demonstrated good practice by providing realistic choices and continuity of care and where all those involved, including the client, participated in a collaborative fashion in the decision making. There was a background then of a complex mix of purposes and agendas, with an element of coercion. I had learned that to minimise the impact of this pattern one needed to be involved at the point of referral to try and redress these imbalances. I began to feel cross that such a situation had built up in this case (losing my usual framing of such situations as 'services under-resourced and over-stretched and in times of crisis selecting solutions such as these to minimise the stress'). I was feeling protective about the client as well.

At this point I speculated about the issues I faced. Clients like Eddie tended to be seen as 'difficult to handle' and staff easily retreat into seeing the problems as lying within the client rather than as an outcome of the quality of the interaction between client and staff. This leads easily to a labelling process, the client being seen as denying, rationalising, angry/violent, manipulative, 'splitting' the staff against each other and so on. Such labelling leads to staff taking on positions of confrontation or avoidance which then tend to make matters worse and create self-fulfilling prophecies. There were indications that this process had begun well before his arrival here.

I wondered how much the current nursing team would be able to cope with him in more collaborative ways. Things had moved on since the incident on the roof in earlier days and we were all more easily able to "go with the flow", a term sometimes used around the department. Nonetheless the personnel in the nursing team changed regularly and it was not easy to predict what the culture was within that group. In addition, the nursing team had identified that when there were more than four drug users at any one time as inpatients (out of a total of eleven beds) then there was an identifiable culture change within the ward, as if the street drug culture was imported in. This was recognisable in a high level of complaints, reduced cooperation, increase in incidents of illicit drugs brought on to the ward, stealing of patients property, conflict over medication levels, and threatened and actual violence.

When this occurred, the nurses came under increased stress and tended to retreat into more defensive ways of working. They did not always feel listened to by Stewart who would complain from time to time about the difficulties he had in getting the nurses to accept enough drug admissions. Under stress he would retreat to a position, as I saw it, of 'why can't the nurses keep these patients occupied and mop up the problems - as a doctor I should not have to be bothered by demanding patients'. William on the other hand had developed a more sophisticated analysis of what nursing was about. He had come to understand that the provision of a care environment was primarily a nursing responsibility and that he needed to negotiate admissions with them, accepting the nurses' judgements about their ability to care for any particular patient, taking into account the patient's needs and the environment on the ward at that particular time. If there were problems he would become involved in finding solutions as he knew the operation of the ward would be jeopardised if crises were allowed to escalate beyond a certain level without intervention. He recognised that there were times when use of his formal authority was necessary in order to support the nurses in maintaining a safe environment. However, to my knowledge he never openly challenged Stewart about his approach.

A further issue facing me was the difficulty having someone injecting drugs on a ward where other drug users were attempting detox. We had been able to achieve the shift away from 'abstinence as the only goal' to create an environment where some clients could be admitted for assessment while still using, but there were occasions when this kind of arrangement created a good deal of tension with other patients. Given the process by which Eddie had been referred, and given his ambivalence about making change, it was highly likely that there would be conflict over his script as change became imminent. It was also likely that he would not be able to proceed through to the point of completely detoxifying from drugs and that he would want to leave with a continuation of his injectable script. This would be another point of conflict as our doctors were very reluctant to provide these, except

under certain conditions, because of inherent health risks and difficulty monitoring them. However, the decision to proceed had already been made and it would have to be followed to some conclusion. This was another factor beyond my control and further evidence to me that I should limit my role.

Then there was the issue of how to work with someone like Eddie. He presented himself simultaneously as a streetwise drug user, as an 'experienced psychiatric patient', as potentially violent, and as vulnerable and powerless with few options for change at this point in his life. I had been able to learn little about his history of relationships but presumed that he had little experience of trust and collaboration.

My usual approach in these situations, where the person is acting in such a way as to minimise their credibility and is likely to be negatively labelled, is to first accept the different 'truths' presented by the person. The challenge is then to find some way of interacting so that the person can experience themself as having choices and as taking some level of responsibility for exercising these choices. Then next to negotiate how I and the service could support or resource these choices, stating clearly any limitations. On occasions such as this, where there seems few openings to begin developing this relationship, the problem the person presents can be the vehicle needed. It then becomes a case of taking this at face value and proceeding with negotiating around the problem in such a way as to develop the possibilities for partnership in expanding choices and achieving change, no matter how small to start with. Once small changes are identified, then these can be 'cheered on'.

This approach does not mean that offensive or oppressive behaviour be ignored. It means finding the level at which the person can accept some responsibility for it then both challenging and supporting them in taking it. The wider challenge is to create a care environment in which this can occur and be noticed and affirmed. In this way I believe people can be moved out of 'patienthood' into 'personhood'.

An accompanying belief is that we all learn and develop our sense of self esteem and self agency through making successful transitions, large or small. Most mental health problems occur around times where transition is required but is not successfully negotiated, for whatever reason. Therefore beginnings and endings are important. If I can work with clients in negotiating successful beginnings and endings in their contacts with services, then this will set the scene more productively for any further contacts in the future. Eddie's plea to be helped leave with dignity struck me as particularly poignant. I felt myself wanting to advocate that strongly on his behalf. If we could help him achieve this then he would be more likely to feel he could return at some later stage when the conditions were more favourable. Furthermore other people would be less at risk from the violence which Eddie had hinted had occurred during previous admissions.

These latter considerations lay in contrast to my decision to limit my role and so set up conflicting purposes, because it would be unlikely that I could achieve these objectives within a limited treatment role. I warned the senior registrar of the different outcomes I could foresee happening and we agreed on the need to monitor developments.

So I began work with Eddie with multiple and seemingly incongruent purposes. I had to manage the tensions of working between these two opposite poles. I started off accepting his definition of the problem as being his inability to resist his bizarre injecting rituals which were highly risky and very self damaging. These rituals lasted for up to an hour and afforded subjective relief from distressing thoughts. I set up the conditions in which he could achieve this, involving the nursing team, Eddie and the senior registrar.

Over the period of several days Eddie's goals changed successively, from wanting to detox, to then moving off injectable drugs, to then being able to continue injecting but in a safer manner. With each change of goal, the nursing team and I negotiated how we could help with this and we alerted the senior registrar.

After several days the senior registrar asked me to accompany him to one of Stewart's outpatient clinics to review Eddie's care. He had apparently been "splitting" the staff and the senior registrar needed to review how to handle the situation with Stewart.

By way of comment at this point, I had recently discussed with two men on the nursing team what constituted a 'difficult case' for them. They both thought the primary indicator was when the staff were "split" over them. This was a jargon word within mental health circles, originally from Object Relations psycho-analytic theory, indicating that the patient constructed different staff into either 'good' or 'bad', with the consequence that each group took either a positive or negative view respectively of the patient, and thus came into conflict with each other. It contains a partial recognition of the interactional nature of reality, but tends to be used in a more pejorative sense in which the outcomes are seen as due mainly to the patients manipulations.

I was rather surprised at the "splitting" comment because I thought we had handled that by keeping abreast of Eddie's ambivalence and changing goals and had kept each other informed about what was happening. On the other hand I was pleased the senior registrar had suggested a wider meeting than he and Stewart alone and outside the usual routine meetings which did not always have the relevant people present. It was usually a role I played to collect together all those involved (even though this meeting was not to include a nurse) and I was pleased that someone else was picking this up.

I decided to keep to my limited role and accept his invitation as it stood. After all the decisions would be about drugs and that was their realm of authority and responsibility. In addition, Stewart's outpatient clinics were not a setting for collaborative and authentic inquiry, where people could acknowledge uncertainty or 'not knowing' very easily without making themselves very vulnerable. Stewart ran his outpatient clinics in a very leader-centred way with little dialogue occurring between team members. He often had medical students sitting in and would without warning throw a question to one of them and then engage in a socratic dialogue for several minutes while the rest of the team had to sit and watch. This went unquestioned, this was how medical students were taught. Nobody challenged because they did not wish to be part of the process.

Despite all the reasons I could see for keeping to my limited role, I had mixed feelings about the process. On the one hand I felt I wanted to take a back seat in the decision-making for all the above reasons. But I was also feeling a little 'bloody minded', thinking to myself: "I am tired of mopping up the mess around doctor's failure to keep full responsibility for the consequences of their decisions about drug prescribing. Let them deal with the consequences this time."

Then there was another voice which was saying: "But Eddie is very preoccupied with his script, you can see trouble brewing over this, you are concerned that he does not paint himself into a corner and that we find a way of working with him which gives him meaningful choices and allows him to participate in as collaborative a way as possible. How are you going to achieve this if you take a back seat in the drug discussions?"

Another voice was saying: "Maybe you are a bit perfectionistic, can't allow others to make mistakes. You have had that feedback before. Maybe you should stand back and let them have a go."

After hearing from the senior registrar and myself (keeping to my limited role, describing the outcome of my treatment interventions), Stewart made his views clear. "If he's serious about detox then we can't wait longer than a further week for him to deal with his compulsive injecting problem and get onto oral drugs. If he does not want to detox but merely deal with his injecting, then OK we can give him a bit longer providing his referring district are willing to pay for this. On no account am I willing to discharge him on injectable drugs. His injecting is too risky and I do not want to be responsible for it continuing."

I was caught in a further bind. "I can understand Stewart's reasoning and it is straightforward. However, Eddie does not feel as though his injecting is under his personal control and he came here in the context of his drug service unilaterally withdrawing his script. If he does not feel he can proceed with a detox and if in the short time available cannot deal sufficiently with his compulsive behaviour to switch to oral drugs, then it seems unfair to discharge him without an injectable script. But on the other hand, its not my job to make decisions about prescriptions, I have given my point of view and the doctors must cope with the consequences of this decision."

This internal dialogue left me feeling anxious, but I was in a bind. If I advocated a different approach based on my private understanding of the case this would not feel timely. Things had gone too far and I had no power to effect the outcomes I would like. But I did not like myself for not giving voice to how I saw things.

With these conflicting internal agendas, or voices, I offered to be present with the senior registrar and the key nurse in discussing the different options with Eddie. This seemed appropriate to my limited role in that I was not up to date with his current thoughts on what he wanted to do and so thought that it was important that all three of us meet with him to minimise any further confusion. But I also harboured hopes I could keep open the possibility of as full and open a collaboration as possible in the circumstances.

Eddie elected to meet us in his room and he made it clear he understood the options he was being offered and clearly voiced the dilemmas he was in. Consequently he had decided to leave. He then asked for an injectable script, hinting that it would need to be larger than the one he had been receiving during his admission otherwise he would probably need to obtain additional 'street' drugs. This was a familiar 'opening gambit' which I had observed frequently when dependent drug users were requesting a script from a doctor. I anticipated that we were in for conflict.

At this point I suggested we take a break from the meeting so that as a staff group we could consider his request. I needed to hear how the other two were making sense of this and what they wished to do so that I could decide what role I should play.

This situation had all the hallmarks of being a repeat of how Eddie had left previous treatment/care situations and had the potential for unnecessary conflict and possible violence which I was keen to avoid for everyones' sake. In our break I voiced the view that while it was clearly the doctor's prerogative to decide, I felt that there was grounds to give Eddie an injectable script for up to two weeks to enable him to find accommodation somewhere and register with a drugs service if he so chose. I ran over again the circumstances under which he came here, that he was already on an injectable script anyway, my belief that he would not accept an oral script without escalating the situation, my belief that if he left in anger it would make it extremely hard for him to come back in the future, and that he was clearly not able to give up injecting as it had a strong compulsive element which meant it would not be under his personal control without some intensive psychological treatment. I also pointed out that Eddie had repeatedly asked for us to work with him to avoid such a situation.

The senior registrar's position was that he had been willing to prescribe injectables until he had heard Eddie say he would probably use street drugs as well, in which case the whole point of prescribing was lost. The nurse took the position that Eddie was clearly being manipulative and to go along with his request was to give in to his manipulation. Both these positions had a strong 'truth' to them and I began to doubt whether I was giving Eddie too much 'benefit of the doubt'. Was I being "pathologically benevolent and positive" as my colleagues sometimes teased me. The senior registrar and the nurse reiterated their agreement with each other.

At this point I realised I had decided to depart from my limited role. I felt I had to see this through rather than opt out at this stage. Perhaps there would be something I could do yet to achieve the most 'dignified' departure possible in the circumstances. So, I registered my discomfort at the decision but said I would go along with it because it was the senior registrar's prerogative.

As an aside, I recall that in my reflective diary at the time I also noted that I had felt an obligation to share 'the dirty work'. This was an old agenda which arose at times when I was feeling uncertain or ambivalent about what role to take in relation to nurses and doctors in inpatient settings. I related it to my early experiences in acute psychiatric ward of feeling left out of the action and feeling it was perhaps because I had not 'worked hard enough'. This latter was a familiar script arising under stress. It was also grounded in the current context. The nursing staff had been making comments recently about the "upstairs/downstairs" divide. My reading of this was that the comment tended to be made when they perceived themselves as working in isolation and not feeling supported by the consultants, arising usually when there was a particularly demanding group of drug users on the ward. But it was also generalised to most senior staff whose offices were upstairs from the ward.

Eddie became predictably angry on hearing of the decision and argued his case more strongly. The senior registrar alternately stuck to his guns or sat listening to him and tried to placate him by empathising with his anger. The nurse similarly tried to placate him. I said nothing initially. But the situation began escalating as Eddie became increasingly angry in response to my two colleagues responses. He became increasingly challenging of their decision and at times put what I thought to be a powerful argument in his favour and I found myself agreeing with some things he was saying. Yet at the same time I did not want to undermine the senior registrar and did not want to intervene in a way that got me involved in assuming responsibility for drug decisions.

However I was feeling increasingly uncomfortable about the conflict as I could not see how it would end with mutual agreement and the other possibility was that Eddie would become physically violent as he was pacing around the room, picking up his belongings and vehemently throwing them into his bag. I could not read clearly what he might do. I was becoming impatient with both the senior registrar and Eddie. I was dismayed that Eddie seemed to be digging himself into a hole and was not able to hear whenever I attempted to say something to him. I could not work out what the senior registrar was thinking, his statements said "no to injectables" but his behaviour suggested he might be swayed. What did his silences mean? His continuing the conversation and his reasoning with Eddie seemed to have the interactional effect of increasing Eddie's anger and his statements about being "patronised". While this went on, with Eddie pacing the room, the other two sitting on his bed, I kept watching Eddie's body language closely. As I was squatting against a wall in the absence of another chair I made sure that I always kept the space between Eddie and the door clear so that at no time would he feel trapped in the room. I also avoided being directly in front of him and would move to his side but within his line of vision so that I kept a 'joining' position in relation to him rather than a confrontational position. I would also be in a position to restrain should the need arise.

It was clear Eddie was not going to accept the senior registrar's decision reasonably so it did seem patronising to me to try to prolong the discussion and convince him of the rightness of it. If he meant "no" he should say "no" and end the conversation there and then and avoid further escalation. Being tactful and assertive about a decision affords the other person the dignity of knowing where they stand and assumes they will be able to make choices in the light of that.

Eddie was not indicating that he heard what anyone was saying to him by now, particularly me, and was becoming increasingly contemptuous and blaming and was beginning to misrepresent things said in earlier conversations during his stay in his favour. I was feeling I could not continue sitting on the sidelines and watch this, no matter whether or not the senior registrar experienced loss of face by my intervening. If this was a tried and true method Eddie had evolved over many years of obtaining drugs then it did not strike me as very adaptive and not one I wanted to participate in.

I said: "I think we should stop at this point, we are going around in circles". Then to the senior registrar: "Have you heard Eddie say anything new which changes your mind?" He affirmed that he had and then offered a compromise to Eddie which was accepted in a derisory manner after some further attempts at increasing the dose.

The meeting was ended by the senior registrar saying the 'door was open' if Eddie changed his mind and wished to return. Eddie rejected this out of hand, still angry. Then there followed a moment of humour as Eddie's demeanour lightened and he asked if he could stay one more night as a friend coming to collect him may not be able to come in time. We agreed and all laughed and relaxed. There was a shaking of hands and I could not resist joking to Eddie that he should think about taking up Law. I wondered now whether this had been an elaborate charade and that my concerns had been misplaced - that Eddie was well practised in this routine and that the senior registrar might also have been authentically trying to find a way through for himself.

However, I was left feeling that this could have been managed better, that it had been an unnecessarily prolonged and uncomfortable session and that I may have played a role in that by my silence and by my mixed purposes. It was also possible that I might have undermined the senior registrar in some way and been a party to him doing something against his better judgement. Usually I would have made sense of this over time, through conversations afterwards at opportune moments, through noticing responses to my engagements with the people concerned as our work progressed, through explicitly

linking elements of this case to other similar cases as they arose and seemed to bear contrasts and comparisons. I would hold this frame for some time in my noticing.

However, it occurred to me in my new researcher role, that perhaps this is an occasion where I should be explicit about my inquiring. And perhaps this is a time to explore the usefulness of Framing/Advocating/Illustrating/Inquiring.

I asked the senior registrar and nurse to meet with me afterward and debrief. They agreed but looked puzzled. I framed my request as needing to resolve a dilemma I had felt between taking the client's position on the one hand and acknowledging the doctor's right to make his own decisions about scripting on the other hand - that I had been feeling caught between the two and was wondering how helpful I had been. I advocated that if we shared our perspectives there may be something to be learned from how we deal collectively with such situations in the future. They listened politely but seemed bemused as to why I was wanting to talk about this.

I illustrated by describing my observations and feelings during the encounter. I then inquired of the senior registrar how he had made sense of what had occurred. He explained that he had felt quite comfortable with Eddie's anger and that his silence had been "To give Eddie time to vent his anger and give him a sense that I could contain it, then wait until he cooled down before patiently re-stating my case".

I then inquired of the nurse. She stated that the most important outcome had been to avoid the client 'splitting' the staff and was therefore happy to support the senior registrar's decision in the meeting. She was not bothered by people's anger or that they might leave the ward without conflict being resolved. She did acknowledge that she had felt anxious on one occasion when Eddie had blocked the doorway for awhile. She also felt that my intervention to suggest a break and to question the senior registrar in front of Eddie had given him the message that I would support his 'splitting'.

The senior registrar ventured that perhaps I had been uncomfortable because I was less use to dealing with confrontations and anger because as a Psychologist I was able to take negotiating positions with people and did not have to confront unpleasant behaviour.

These were offered in the spirit of 'helping me in my dilemma' but they were also a challenge to many things I believed in and a challenge to the expertise I saw myself as having. I felt slightly demeaned by their responses. I considered how to respond and realised that these two in their roles were quite used to this type of encounter and did not see it as a particular problem. I did not want to seem defensive but I also wanted them to know who I was and considered that they may be making sense of this situation based on little knowledge about me and how I thought about things. Perhaps it would help if I talked a little about my approach.

I acknowledged that what they had said could be partly true in this setting but that I had worked in other settings with dangerous behaviour. I went on to describe my values and beliefs which underpinned the approach I took to conflict resolution, to the type of relationship I attempted to develop with clients, to respecting the dignity of all. I reiterated my belief that this could have been a potentially violent situation and that in my view we three had inadvertently increased the chance of that by the way we had handled it. This went unchallenged.

At one point in the discussion, both suggested it might have been helpful if I had expressed my discomfort directly to Eddie. I replied that I had tried three times to address Eddie but that he had not heard me - the senior registrar as doctor and holder of the prescription pad was the only person he was interested in talking to. I talked more about how I had tried various positions in the room to interrupt the escalation and that finally the only one I thought would work was to talk directly to the senior registrar. They accepted this.

By this stage I felt that I was 'working too hard' and that I was talking past them. I started to lose confidence that this was in any way useful. I felt myself stumbling as I tried to keep in mind the Framing/Advocating/Illustrating/Inquiring framework. Their verbal and non-verbal responses said to me that I was making much ado about nothing. They were listening politely but without much interest.

It was time to end this but on a positive point where we could gain some agreement about how to do it differently in the future. I asked the senior registrar how in any similar situation in the future I could intervene without compromising his position or integrity. He replied: "Say to me 'I'm feeling uncomfortable with this situation, could we have a break to talk together'. I would be happy with that."

Reflections at the time.

My reflective diary afterwards read as follows.

> "Felt stumbling, hesitant, cross at them for treating it so lightly. Irritated that they may have thought of me 'he can't hack it'. Cross at them for dangling Eddie on a string, why couldn't they have been straight with him. On the other hand am I making too much of this? Maybe they were right, he was an experienced manipulator and I got sucked in. Maybe I was backing Eddie in his fight with authority and doctors. Maybe I allowed my frustration at the power issues around prescribing get in the road. Feel cross at myself for allowing myself to get caught in it. Feel foolish that I tried to influence events from a position of so little power. Maybe I should have stuck to my 'limited role'. Felt Torbert's stuff got in the road. What is authenticity?"
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> "Now, stand back a bit David. What else was going on? I felt inauthentic on two accounts. Firstly in trying to work with complexity within the confines of the limited role I had seen available to me. Secondly although I had departed from that in the spirit of trying for 'dignity' I wonder what I had achieved from my explicit inquiry niche afterwards. I felt I had been preaching at them. I had departed from my usual way of doing things. I had run the risk that they had felt preached at or implicitly criticised. I recognised the familiar 'dance' between doctors and nurses and that nurses have to put up with such situations many times over and develop ways of managing stress by keeping themselves at a psychological distance, keeping their involvement within tolerable limits. Aligning themselves with doctors makes sense if they see themselves as only having delegated and interdependent roles."
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> "Senior registrars have to be both practising to be a consultant but at the same time accountable to the consultant under whom they are working. The boundaries are not always clear. They are in training and they do not develop long term commitments to placements because they know they will move on. They look to nurses covertly to provide guidance and support. Each senior registrar brings their own personal process to these structural arrangements. How could I convey that in the context of this discussion. I had made myself vulnerable by talking about my beliefs and values and I did not feel met in this. How can I proceed as a researcher along these lines? Framing/Advocating/Illustrating/Inquiring did not feel helpful here, it was like paying attention to some smooth involuntary action like walking or breathing and finding that I start stumbling or catching my breath. It could not contain the complexity for me or achieve my multiple purposes, many of which are in different time frames from each other. The nature of the sequencing of the steps constructed for me a linearity which does not fit my natural way of doing things. I felt I could have achieved more useful collaboration by weaving my findings from this case into future cases, bringing in strands moment by moment as they seemed timely. That is my usual way. So how do I balance the things I value about my practice with what these research ideas seem to require of me? "

I was left feeling lonely and isolated in my views. I had discovered the limits of collaboration around an individual case. I felt as though I had tried to achieve 'too much too soon', and had expected too much of the situation in terms of trying to dialogue about the complexities of the work as I saw it. I felt as though I had alienated my two colleagues from me, and me from them.

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I will add further reflections on this case for both research and practice at the end of the chapter. The following story has a similar theme, where I intervene in such a way that I seek to maximise clients' participation in the decision-making. I see this as a more successful attempt, where, unlike my approach with Eddie, I engage with the complexity from the start. However, I was left again with a feeling of isolation.

Knitting as a metaphor for practice.

The following case is one in which the metaphor of 'Knitting' occurred to me as a description of what I did in relation to the client, myself and other members of the team. I also became aware through this case of the unique role that I perceived myself playing in the department. I was to learn about the degree of influence it afforded me and also the degree of isolation and vulnerability. This story also connects me with past experiences in New Zealand in working with individuals from different cultures, and the complexity which is created by trying to discern and work with the different world views of the key participants.

I am selecting this story to show a development in my practice, where I am not consciously putting research frameworks into the foreground. I pay more attention in action to the different constructions of the individuals involved and how these might be informing the patterns of relationship around the problem. I was not awarely attempting to use ideas from Action Inquiry - it shows rather the emerging influence of listening more for the ‘stories’ and trusting that the action will flow from this.

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Sushi's Story.

Sushi was a middle aged woman who was referred initially to Stewart from a neighbouring health district. She had become addicted to prescribed opiate pain relief because of a protracted and severe pain problem. She had been through exhaustive physical tests as well as several surgical procedures over a five year period to try and locate the source of the pain, with only occasional and temporary relief. Stewart had agreed to admit Sushi to withdraw her from opiates and to assess her pain problem when drug free.

Several days after her admission, Stewart asked me if I would assess her to see if I could help her with some psychological approaches to manage her pain. The medical reports he had read indicated that further physical investigation was not only unlikely to reveal anything new, it was likely to compound the problem. Particularly, any further surgical investigations would cause scar tissue and adhesions which could exacerbate any pain problem, and become sources of pain in their own right. There was a strong sense that the medical services had run out of options. Her GP had clearly reached the end of his tether and was stating that he could only go on treating her under certain conditions and was unwilling to continue providing opiate pain relief.

In addition, Sushi's husband was in serious difficulty in his professional life because it was perceived by his colleagues that his involvement with her problems was interfering with his work. His colleagues were on the point of unilaterally excluding him from their business. Also, there was an issue concerning inappropriate prescribing of restricted drugs to Sushi within her own health service and the medical authorities investigating this had been in touch with Stewart. There was considerable anxiety surrounding Sushi and her family, and it was felt by the staff. A lot seemed to be riding on the outcome.

I was keen to respond to Stewart's request because he had been discussing with me from time to time the possibility of extending our expertise in this area. Few services worked with dual problems of drug dependence and chronic pain (which was well established in the literature as having behavioural and psychological components. I was interested to see if we could work together in a more collegiate fashion where substitute prescribing was not going to be an issue. also wanted him to know about other skills I had to offer and was interested to learn more about his, in order to see to what extent we could work together where there was more mutuality.

Before meeting Sushi I decided to gain a broader picture first by talking to the nursing staff. She was Asian, as was her husband, and the nursing staff had taken this into account in care planning with her. They had asked the kitchens to make appropriate dietary arrangements, had supported Sushi in allowing her family to supply some of her own preferred food, and had accommodated to the presence of family members to share in her care. She had a daughter who had just started her first job after completing university, and was now living away from home. Her son was studying for A levels and still living at home but due to leave for university the following year. The two children visited and stayed as often as they could, and the husband visited in the evenings. The husband was a high status professional and Sushi a worker in her local community, developing educational resources for women.

I also read her records and saw that she had been referred to the psychotherapy section of the hospital many years ago for treatment of depression. With this information I began developing some tentative hypotheses in relation to family, culture and migration issues.

My first impression in talking to the nurses was their high level of anxiety and distress. Sushi had been in constant pain and required assistance in moving about and in toileting. She spent all her time in bed even though she could find no tolerable resting position. She was in tears most of the time and expressing feelings of hopelessness and despair, often in a manner distressing to those around her. The nurses found her difficult to engage in working with them because of her high levels of distress and were only able to manage caring for basic physical needs.

Sushi was also saying she did not need to be in a mental hospital because her problems were medical. The nurses were feeling distressed at her distress and feeling helpless in relation to her continuing pain. I questioned whether they had noticed any departure from this pattern and found that she appeared to be less distressed when someone was with her, and most distressed after her family had left after visiting. However she was agreeing to pursue the withdrawal from opiates despite the pain as she evidently felt very ashamed of her dependence.

My knowledge of pain management required that some time be initially spent with the person establishing their beliefs about causality and in developing an understanding that psychological treatment did not imply the pain was imaginary or in any way fictitious. The next step is establishing a partnership relationship in which the person is willing to take small risks in becoming more physically active and in developing more self awareness about how the pain 'works'. These steps are initially counter-intuitive to people with pain problems who believe they must rest and guard against the pain both physically and psychologically. (I had experienced a prolonged and on occasions severe pain problem myself, and so knew this with a personal confidence). This can lead to a wide range of interventions involving other therapists, such as physiotherapists, as well as family members who may have become organised around the problem in ways which inadvertently maintain it. Medication prescribed for pain relief must be managed in a particular way if the person has become dependent on it to the exclusion of other strategies.

In addition to this broad framework, I was aware from both past experience and the professional literature that different cultures not only experienced pain differently, but had different explanations and solutions. Asian health workers had written about how in western countries their people often presented a pattern of physical problems to medical services as code for psychological distress, whereas their western counterparts would more likely present problems in terms of emotional difficulties. This was explained in several contexts: the context of linguistics, with fewer words in their vocabulary to express psychological distress as we know it; the context of values; and the context of certain patterns of social and family organisation. This body of literature also highlights cultural difference in the degree to which the interests of the individual are inseparable from and subordinate to the interests of the wider family and social group. This was seen as being historically adaptive to a rural and often subsistence lifestyle in their country of origin.

Within these frameworks I tried to makes sense of the requirements of Stewart and the wider medical network, the nursing team, and Sushi and her family. In terms of my role I wanted to begin my assessment within a family and cultural context. However it would be difficult to do this within the current climate of distress. I decided some immediate action was required which was not within my brief, but which was necessary for me to succeed. My initial hunch was that Sushi needed someone to be with her constantly, that she would experience being alone in a room as a form of alienation and

fragmented identity (this was a generalisation from my experiences with Pacific people who, like Asian people, saw their identity strongly embedded within the family group and who became very disturbed at being alone in hospitals). It was clear the nursing team could not manage this within existing resources, so I contacted Jan and asked how we could achieve this. She agreed to bringing in someone from the Nurse Bank specifically for this purpose.

I then contacted the hospital physiotherapist and asked her to assess and see if she could help Sushi find more comfortable resting positions and give advice about moving her about more easily. It turned out she had worked with Sushi in a former job and was not hopeful of being able to do anything for her, but was very willing to try again. I had mixed feelings about taking these actions as it felt as if I was moving into the area of nursing care and did not wish them to feel disenfranchised. However, on the other hand they were acknowledging they were not coping and on checking I found that they were happy for me to take the lead.

My next step was to visit Stewart to explain how I was approaching this case. I needed his support because without it the nurses would feel divided if he expressed a wish to take things in a different direction. I also needed to know his views on how he wished to approach Sushi's requests for further medical intervention. I had learned that one of the junior doctors, who had recently spent some time working in the relevant medical area, believed there were some further possible explanations for her pain which had not been excluded. I wanted to make sure he knew this. And finally I needed to know how he planned to meet her requests for alternative medication for pain relief, as this would have a bearing on how alternative pain relief strategies could be introduced.

Stewart then made the decision that a further particular test was indeed warranted. We realised we would need more time and that there was some work to do contacting health services from Sushi's home health district to ensure we had all the information available, as well as gaining agreement from the purchasing authority for an extended stay. We negotiated who would take on which tasks. I had been party to some of the negotiations about service agreements with other districts and knew what needed to be done in this regard with the administration team so took on the task of arranging extended funding. I suggested that it would be appropriate for us both to meet with Sushi, for me to introduce myself and for us both to explain how we wished to work with her from here on. I thought it would be important for Stewart to outline the plan.

We did this and I was mildly surprised to feel as though I was in a ward round of a general medical ward, with the consultant doing his daily review (I had recently been in a medical ward as a patient). We did not have ward rounds in this way and I had never seen Stewart interacting with patients apart from bargaining with illicit drug users over scripting. He briefly but sympathetically asked Sushi how she was feeling, introduced me, then outlined the care plan and confidently predicted that it would be helpful to her. This seemed to me to run the risk of not meeting how Sushi saw the situation at all, but she did not signal disagreement. Indeed she agreed that she would need some psychological help. I explained that as a first step I wished to meet with her together with her family so that they could help me begin to understand what seemed to be a very complex situation. She was willing to do this.

Over the next few days I negotiated with family members about convening a meeting with them. I checked regularly with the nursing team and supported them in working with her and the physiotherapist to help her become more comfortable. She was less distressed since the advent of more continuous nursing care and was even contented to be alone from time to time. However I felt some pressure to be moving more quickly by doing some work with her myself, but decided that it would be premature without first understanding what territory I was working in.

Both the son and the daughter visited Sushi during this period and requested to see me. I met with both briefly on separate occasions and heard their very clearly stated dilemmas about their worry and concern for their mother versus their need to get on with their own lives. The son was particularly vulnerable in this way and spent a lot of time caring for his mother with the nurses, often fiercely advocating his mother's needs if she was in distress or discomfort. The daughter provided a marvellous cross-cultural bridge as she was keen for me to understand that she stood in two worlds and that I must appreciate what the issues were for them as an Asian family. She was particularly articulate about her need to get on with her own life.

The husband was working long hours to ward off pending challenges to his position from colleagues and could only come during the evening some days hence.

It was tempting to succumb to the many anxieties and begin intervening with the information I had, but I was clear that I first wanted to meet with them all as a group including the husband. I needed to gain a picture of how they were dealing with this collectively as well as individually before then finding a focus for work on which all could agree. I had to persuade Stewart to be patient as he was worried that nothing would change and we would have her "stuck here" in her continued distress. Although I had talked about my rationale for approaching thing this way, I do not think he fully understood. I had a strong hunch then that he did not know how to manage this case but could not say so overtly. However he agreed to go along with my plan.

I finally managed to convene a time when all could visit but at the last minute the daughter could not attend. I wondered if this was a metaphor for her statements to me about the need to develop a separate life, and was it a sign of confidence that she felt I had heard her?

I felt the need for a co-therapist for this meeting to provide support in observing the process and to ensure Sushi's voice as a woman would be heard in the session. As Jan and I had worked together with families from other cultures in the past I asked for her to act as an observer. I needed to have support from someone who would know what I was trying to achieve in dealing with the problems this way as it felt a lot was riding on the outcome. I had counted on the daughter to provide the cultural consultant role, but would have to do without.

I was surprised to see Sushi walking unassisted into the session, although she came with pillows to support her. By now she had completed her withdrawal from opiates. Within the family session it emerged that there had been a long standing issue about Sushi's coming to this country for an arranged marriage and her grief at separation from her mother and family. As her children came up for separation Sushi was facing a second abandonment. She had made herself a strong role as centre of the family and mainspring for all their developments. While I joined with the men, Jan joined with Sushi. It emerged that each member of the family were facing difficult transitions in their lives. At one point Jan offered to Sushi that perhaps her role was also to carry the pain for everyone in the family. There was a long silence and tears from all as Sushi nodded.

We moved on to what they wanted to do about this. The son spoke for all the family in saying that they believed there may still be a physical cause for Sushi's pain and that they felt they had to pursue this to the point where they got a clear message one way or the other before knowing what to do. In the meantime, Sushi wished to go to a homeopathic hospital they knew of which would provide care which was consistent with their cultural beliefs.

I asked when they would like this to happen. "Now" was the answer. "Would you like me to arrange it then?" "Yes please". Sushi then added, "When we are through with this I would like to come back and see you, I think I have a lot of things to sort through." (She never did). There was considerable relief within the family and I sensed that they felt as though they were back in charge of their lives temporarily.

I spent the next half hour locating Stewart, gaining his agreement as responsible doctor for arranging discharge, then getting the junior doctor on duty to arrange for medication and other formalities.

Some time later I sought Stewart out to debrief. He agreed to write to the senior surgeon in Sushi's Health Authority and ask him to write a definitive report based on information from all the specialists who had seen her. This would serve the purpose of bringing together all relevant medical information to inform any further decision-making about investigating possible physical causes of pain. Apart from that he showed no real interest in talking more about the case and seemed relieved that our part in it had ended so smoothly.

Reflections at the time.

I felt as though I had done little direct work with Sushi herself and that I had only seen a brief snapshot of the problems she and her family were facing. But I felt as though I had facilitated a process which at least empowered people to make choices. So what was this process? It seemed to me that I had visited all the different resource points in the department and connected together previously separate, or only partly connected, threads into some more meaningful pattern. I had facilitated the 'knitting' of this and felt pleased with the result. It felt that a slightly more robust garment had been begun. However, I did not feel I had a language to be able to explain this to my colleagues and felt therefore that my understandings would remain private.

I wondered why no one else had done this, had taken charge in the way which seemed necessary. My answer to myself at that time was that I was able to do so because I had developed a connection with the various groupings within the department, in addition to the client group, and therefore had access to their roles and views of the world in such a way that I could help make the connections across the groupings to deal more collectively with the presenting problem. I felt located in the centre of the department, not feeling as though I belonged fully to any one of the parts, but linking with each. This was an intriguing realisation to me but not one I could articulate easily to colleagues. I realised that this was one outcome of the process by which I had entered the department on first starting the job. I had wanted to 'map the system', learn what the elements were, how they changed over time, and how they linked with each other. This position I had occupied in working with Sushi seemed to be a 'niche' I occupied on my own and with that came a dual sense of connectedness and isolation/vulnerability.

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I much later discovered that I was seen as: "David is our psychologist but he does lots of other things" (on being introduced to a visitor by a physiotherapist who later joined the department); " David is the only one who negotiates admissions where everyone is clear about what is involved" (the ward Charge Nurse to William); " This is David, the only other psychologist I know who gets his hands dirty." (a colleague who runs a clinical psychology service to local Social Services children's' department, introducing me to her new colleague); "You do not work like any of the other psychologists I have worked with, you are much more pro-active and involved in things." (a senior nurse after having lunch together with several other psychologists). This was affirmation and lessened the sense of isolation. I was to discover also that it was not incidental that these were all women who had made these comments.

Commentary on these two stories.

Firstly, I would like to articulate further some of the growing awareness at the time of these two stories which is not contained in the reflections above. Then I will give a retrospective narrative comment as the researcher “I” creating this final research account.

Growing awareness.

In terms of what I learned for practice from these two stories at the time, I began to see more clearly what the issues were for dealing with 'complex cases'. Many of these could not be solved at the level of the individual client, but needed to be solved at a wider level of planning the 'patient journey'. In other words, looking at complex cases as a group or class, assessing what their requirements were likely to be, what resources and skills were needed, and what administrative and decision-making procedures were required to support the clinical process. At that stage, I was not sure how many of my clinical colleagues shared my frame about 'complexity'. Inquiring into this would need to be the first step. It is another story I will return to in a later section.

In terms of myself as a researcher at the time, I considered only that I could not see much use for Torbert's framing/advocating/illustrating/inquiring framework as I had chosen to apply it. In terms of his levels of development, I speculated about myself as being either an Achiever or a Strategist. I saw myself sometimes operating as an Achiever but borrowing from the strategist when I framed events in wider historical, organisational and social contexts. At other times I could see myself as operating in Strategist territory, working outside existing frames, and in so doing obtained a possible explanation of my sense of isolation and vulnerability. Torbert sees individuals operating at this level as being outside

the frames of 'craft logic' and working beyond the outcomes expected within them. The contradiction inherent in Torbert's model of leadership is that as soon as one begins to think about levels of development beyond the achiever, there is no 'craft language' with which to talk. One is into the realm of many languages which are beyond the usual realm of discourse for professional practice in mainstream health settings.

In relation to his model of power, I speculated that there may have been elements of at least three types at play in these two stories. I considered that I had exercised unilateral power in Eddies case by refusing to play my usual role, but in so doing may have disempowered Eddie. I considered that there had been clear uses of diplomatic and rational power in my gaining agreement to do things a certain way by virtue of my dialogue and by making a 'rational' case in Sushi's story.

As for transforming power, I found it harder to speculate about this at that time. There were paradoxical elements of my style which would suggest a use of power or influence beyond the unilateral, diplomatic or rational forms as described by Torbert. In Sushi's story all the participants were feeling powerless and there was a clear text to 'do something'. I did something by supporting other staff in making her as comfortable as possible in the circumstances, but I also said 'let's do nothing' until we have sufficient information. This reframing enabled myself to do something I hoped would prove more effective in the longer term and had the interactional effect of lowering the overall level of anxiety (including my own). 'Doing nothing' can have the effect of allowing participants to transcend their immediate anxieties and become more aware of 'what else' is going on outside their immediate awareness. In Eddie's case I was clearly hoping for more 'just' processes and outcomes, but I felt that very little that could be described as transformative had occurred there.

I did not feel that the ideas from Torbert resonated much with my experience at that time. I recall starting to feel frustrated and angry with myself at that point. I remained preoccupied and muddled about how to begin a more public dialogue about how I was seeking to work, about how to bring practice into the domain of research. My perceptions at the time were that I would need to be able to exercise more authoritative forms of leadership if I were to begin a research project as I had envisaged it. I did not see myself as having or being able to use the influence I believed was needed. I was becoming more frustrated and confused at the continued dissonance between researcher and practitioner, and I was not able to resolve this within the frameworks available to me at the time.

A narrative comment..

My journey at that time was to find a way of authentically beginning the research process as I understood it to be. My use of Action Inquiry strategies was secondary to this, a vehicle for finding a way forward and not my primary focus. Nonetheless I will make a brief retrospective comment here on my implicit and explicit use of Action Inquiry.

I am able to look back and see aspects of Action Inquiry present in the encounters which I could not apprehend at the time. Because of my frame about research as necessarily involving the explicit agreement and collaboration of others in use of inquiry strategies, I was blind to those aspects which Torbert (1981) describes as characterising an inquiring interpersonal strategy. For example, he warned that at any one time interpersonal inquiry was a more or less distorted and incomplete process in which paradigm clashes are to be anticipated (and welcomed as an opportunity to test assumptions). Therefore, it should not have been surprising to me that I encountered such a 'clash' in my attempts to consciously use his interpersonal strategy in Eddie's case. Also, a comparison can be made against one of Torbert's (1981) characteristics of 'experiments-in-practice': that the test of whether 'any given action is aesthetically appropriate, politically timely and analytically valid is whether it yields increasingly valid data about the effectiveness of any acting system.' Both cases offered such 'data' to me, one was about how to 'get it wrong' and the other about how to 'get it right'.

Furthermore, in Sushi's story there is considerable use of Torbert's framing/ advocating/ illustrating/ inquiring, but I recognise it as being implicit in my own personal style. The difference between the two cases regarding degree of success, in terms of Action Inquiry, is that in Eddie's case I accepted the existing dominant frames (although reluctantly) and attempted to work within them. I was not authentically inquiring into the frames held by others and not seeking to offer or 'co-create' alternatives until the end, at which point they were rejected. On the other hand, in Sushi's case I sought to inquire

into the frames of all the participants from the outset, created a new frame within which we could all begin working together, then continued the 're-framing' as I went. This use of reframing can be seen as an exercise of a transforming power, and it is an issue I return to later in the journey.

A further difference between the two cases exists in the relationships between myself and the doctors. In Eddie's case I constructed the doctors as having more power in relation to prescribing and myself as being relatively power-less, and this construction had the effect of positioning me in 'supporting' care. Alternatively, in Sushi's case there was a shared agreement amongst all the participant's that prescribing would cease and hence there was no implicit struggles for control around its continuation, Instead, the doctors appeared to feel relatively 'power-less' in the face of her pain and distress and both invited and allowed me to 'lead' care. I did so in a way which was unexpected, and in a way which I felt unable to share explicitly because the frames within which I was operating were too far removed from those held by others in that immediate setting. However, in retrospect I can see in Sushi's case a greater degree of willingness among medical and nursing staff than I had experienced earlier in being prepared to move outside some of the implicit 'rules' and assumptions about patient care in the ward. Whilst I could recognise this a practitioner, I did not know how to transfer or translate into a research frame of reference.

Moving away from Action Inquiry and back to my journey of that time in finding an authentic mode of entering research, Sushi's story further highlights a contradiction. If this story alerted me to the increasing awareness I was placing on constructions of those involved in any one case, then this gives rise to some interesting questions: “Why were my own constructions about myself as a researcher not within the frame; what was it about my own self-awareness, my own practice approach, the research methodologies I was using which positioned me outside a consideration of how the constructions of *all* the actors were influential in informing action and creating meaning?; what ‘stories’ of my own were not present or given voice?”

In the next chapter I will present the process of how I was offered the beginnings of some answers to this question through considering the a feminist critique of social science and the role of gender.